COPING WITH COMMUNITY HEALTH FINANCING:

Illness costs and their implications for poor households' abilities to pay for health care and children's access to health services.

A Study for Save the Children UK.

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II. ACRONYMS

BIF	Burundi Francs (used interchangeably with FBu)
CURE	Credit d'urgence de rehabilitation
CAM	La Carte d'assurance Maladie (disease/illness insurance card)
FBu	Burundi Francs (used interchangeably with BIF)
FGD	Focus Group Discussion
IDP	Internally Displaced Person
ILO	International Labour Organisation
IMC	International Medical Corps
IMF	International Monetary Fund
(i)NGO	(International) Non Government Organisation
MFP	La Carte de la Mutuelle
MHO	Mutual Health Organisation
MoH	Ministry of (Public) Health, Burundi
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Cooperation and Development
SAP	Structural Adjustment Programme
SC (UK)	Save the Children, UK
STEP	Strategies and Tools against social Exclusion and Poverty
STD/STI	Sexually Transmitted Disease/Infection
UNDP	United Nations Development Programme
US$	US Dollar
USD	US Dollar

III. EXECUTIVE SUMMARY.

PART ONE: Introduction and Background

Burundi has been undergoing civil conflict since 1993. The security situation, though not resolved, has become more stable. More than five years of conflict and two years of economic sanctions imposed by neighbouring states have crippled the economy, worsened social indicators, and limited access to basic social and health services.

A lack of funding for health services has plagued the process of decentralising health care management and affected the provision of health care services. In real terms, the total annual public sector budget, and hence, spending in the social sector, has been shrinking year on year. The health and education sectors receive the smallest allocation of funding compared to all government departments and are hampered by repayment of debt. There has been a decrease in the percentage of total government annual expenditure allocated to health (from 5% in 1999 to 2.2% for 2003). This equates to US$2.1 per-capita public spending on health care in 1999, falling to US$0.7 for 2003.

Currently additional health care finance is raised through pre-payment schemes, voluntary for the informal sectors (CAM cards) and compulsory (through monthly deductions from salary) for civil service employees (MFP cards). The success of these schemes in both raising sufficient revenue and use of revenue collected has been questioned. As an alternative, cost recovery schemes, through raised user charges paid at the point of service use, are being piloted in Gitega and Mwaro provinces, and have been adopted in various formats in other provinces. The aim of the government however, is to implement a countrywide cost recovery scheme – a strategy whereby communities, both through user charges and pre-payment schemes, finance the health care system.

The prevailing concern is that cost recovery is being promoted in order to raise finance for public health care provision at the expense of neglecting other health policy objectives, such as providing affordable and good quality care to all those who need it. It is feared that rising user charges will discourage vulnerable groups from seeking health care, and in cases where health care is sought, the costs will significantly impact on low income households whose standard of living is already diminished.

PART TWO: Study Rationale

There is a lack of data and evidence to support *or* refute the concerns outlined above that the community *cannot* cope with the hypothesised negative impacts of cost recovery schemes or, indeed, to support the idea that adequate finance can be raised and sustained through these cost-recovery schemes in this health care system.

The broad aim of this piece of research is to evaluate the impact of the financial costs on health seeking behaviour and the households' behaviour and ability to cope with the burden of health care costs. For the purposes of the research a mix of quantitative and qualitative techniques were adopted. The research focused on three provinces in central Burundi - Gitega, Mwaro and Muramvya - selected as potential pilot sites for community financing schemes due to their relative safety and largely rural yet stable populations.

Data were collected at the community level through a household survey, focus groups and key informant interviews. Supply side data were collected at the facility level through the facility questionnaire.

PART THREE: Research Findings

A. Demographic Profile

- Household size varied significantly between provinces. The total number of household members (4.54) and the number of members over 18 (2.05) were smaller in Gitega. However, household dependency did not vary between provinces (average 58%).

- Population statistics are similar to those for the region: 50% are under 16. Females dominate between the ages of 6 and 50.

- For those respondents that have completed their education, 20% received no formal education. Gitega had significantly more respondents with no formal education.

- A large proportion of respondents work all year (43%), 80% of these work as subsistence farmers on family owned or on rented land. Higher proportions of women in all provinces work the land whilst men are more likely than women to have other jobs.

- Cash availability is low. Only 10% of respondents who work received cash remuneration for employment undertaken. Average per-capita consumption is 38,013BIF (45USD) and consumption levels in over 60% of households are under the $1 a day level. This compares to the proportion of the population living in extreme poverty in Burundi (proportion of population below $1 a day) recorded as 36.2% in 1999. Gitega has significantly larger proportions households in poorer groups.

B. Patterns of Illness

- 1189 (16%) of those surveyed (7,404) had been ill within the specified recall period (4 weeks prior to the survey). Common diseases listed were: Malaria, respiratory problems, and measles, intestinal worms, flu, and diarrhoea, which were common illnesses amongst children.

- The pattern of illness prevalence revealed that reporting of illness was lowest among the 6-15 age group (11%) and highest in the over 50 age group (25%). Illness reported for the youngest age groups, in particular those under 5 (19%), may be under-reported due to the fact the early signs of illness are difficult to recognise in a child.

- Proportionally the prevalence of illness reported was significantly higher in women in all age groups (except youngest). This is typically seen in all health care systems and is commonly attributed to the fact that women more often require routine treatment/interventions (that are often not illness but associated with child birth/pregnancy), but also that males may systematically underreport illness.

- The prevalence of illness varied significantly across provinces with Gitega reporting higher illness rates (20%) than Mwaro (14%) and Muramvya (15%). However

this difference could not be explained by differences in socio-economic status, as the prevalence of illness did not vary significantly by quintile group.

- Over all households surveyed, forty-nine percent had at least one member who reported having been ill within the 4 weeks prior to the survey date. Significantly more households in Gitega (59%) reported having at least one member who had been ill within the recall period. However, the burden of illness did not vary significantly by province or socio-economic group. On average within the households reporting illness, 1.6 members were ill (i.e. more than one household member was ill during the recall period).

C. Health Seeking Behaviour

- 690 (81%) of those reporting having been ill within the recall period, sought health care outside of the household. 183 (12%) chose not to seek care outside of the household.

- Ill persons in poor households are less likely to seek care outside of the household (74%). Rates of non-consultation were significantly higher in poor groups (13%) compared to wealthier group (6%). Similarly, poor households sought health care outside of the household for proportionally fewer household members compared to households in wealthier quintile groups. Additionally, respondents from poor household were less likely than those from wealthier household to go onto a second visit and are thereby (since recovery rates not likely to vary) more-likely drop-out from health care system after one visit. Furthermore, significantly fewer respondents in Gitega, as a proportion of those ill, sought care outside the household (73%) compared to other provinces and households in Gitega sought health care outside the household for proportionally fewer members.

- For those that chose not to seek care outside of the households, the decision to not seek care did not vary significantly by type of illness. Distance was not rated as a significant barrier in seeking care. The distance from the household to health facilities was not significant in the initial decision to seek care (i.e. barrier in accessing care). Most respondents (95%) lived within 1km of a health centre (public or private). The most often (34%) cited reason for not seeking care outside of the households was that they 'could not afford to at the time'

- For those that sought care, there was no difference in delays in seeking care between wealthy and poor groups. However older age groups were more likely to delay seeking care. Care outside the household was sought for youngest age group (<5) and 16-30 age group more frequently than other ages. This did not vary by gender.

- For those people that did seek care outside of the home, the choice of facility varied by quintile group. Most commonly, respondents seeking care outside of the household chose to visit a public health centre (53%) (54% from poor groups, 50% from rich groups) and 23% chose to visit missionary facilities (19% from poor groups, 23% from rich groups). Visits to other facilities were reported much less frequently. Though: respondents from wealthier households were significantly more likely than poor households, to visit a private facility and go to hospital, whereas, poorer households were significantly more likely than rich households, to visit a private pharmacy and a traditional healer.

- Surprisingly, the choice of facility did not vary significantly with the nature of the illness. However, the choice of the type of facility visited, varied significantly with the distance of a private pharmacy and public hospital from the household (i.e. barrier to utilising care). The choice of facility also varied significantly across provinces. In the provinces of Gitega (54%) and Mwaro (68%) respondents more often visited public health centres, followed by private pharmacies in Gitega (15%), and private health clinics/hospitals in Mwaro (14%). In Muramvya respondents were less likely to visit public health centre (34%) and more likely, than respondents from Gitega and Mwaro, to visit missionary facilities (46%) and public hospitals (9%).

- Expenditures incurred in seeking care outside of the household vary between the types of facility. These are likely to impact on the choice of facility.

D. Cost of Illness

- On average, the total health expenditure for a health care visit was BIF 2,478. This is equivalent to around 6% of the average annual per-capita consumption, or just under an individual's average monthly level of consumption. Poor groups spend absolutely less on health care, though in relation to annual levels of consumption, they spend proportionally more (around ¼ of average annual per-capita consumption). The largest component of health care costs is spent on drugs (49%). This is significantly greater in Gitega, followed by Mwaro, and lowest in Muramvya, and is also proportionally greater in expenditures among poorer groups. Following this, the proportions spent on food and outstanding money owed to facilities make-up the next largest components.

- Highest expenditure is incurred in public hospitals where proportionally most of these costs are spent on food. As a proportion of total expenditure, the amount outstanding (i.e. debt incurred) is significantly greater in missionary and public health facilities. Low proportions of debt are incurred in private facilities and pharmacies though this is not surprising given they are unlikely to allow credit facilities. Further, there was no variation in the proportion of debt incurred across all socio-economic groups, suggesting that all groups struggle with costs of health care.

- Health care expenditure in young age groups is significantly the same as all other age groups except those in the over 50's age-group (where spending is significantly higher), suggesting that health care costs do not vary between children and adults.

- Cost and quality were not significantly associated. Quality tended to rated higher in private facilities (private and missionary) compared to public facilities (health centres and hospitals) where quality was rated lower but expenditure was higher in hospitals, or in the case of the health centre, lower. Moreover, waiting times were longer in public facilities and missionary facilities. Better quality was either experienced or perceived by wealthier groups. Wealthier groups also reported having to wait for less time than poorer groups. This could be indicative of type of facility that respondents from wealthier groups visit, where quality is rated more highly, or this may reflect the fact that different socio-economic groups experience differential treatment at the same facility.

E. Household Coping Strategies

- A significantly large proportion (18%) of households in poorer groups have no coping strategy for paying health care costs. Those that do, rely heavily on selling assets (55% and 61% in the poorest quintile groups) or borrowing money from a friend or relative (22% and 35% in the poorest quintile groups) to cover health care costs. These are risky, irreversible strategies and are potentially catastrophic for already poor households who may not be able to recover the costs that they have to pay out or cope when more than household member falls ill, or a household member for whom money was outlaid, dies. Additional 'safety-nets' such as reducing household expenditure or using household savings are not common among this poorest group.

- Although wealthier groups also most commonly sell assets (58% and 44% in the wealthiest groups) and borrow for friends or relatives (25% and 25% in the wealthiest groups), proportionally more households in wealthier quintile groups tend to have more than one strategy for coping with health care costs. As well as selling assets and having stronger borrowing power, they are more likely than poor households to use household savings and reduce their household expenditure until bills are paid.

- However, very few people appear to save explicitly to cover future health care costs. There was an example of a savings scheme in Mwaro, though this was not specifically aimed at health.

F. Cost Protection and Risk Sharing Strategies

- Only 29.4% of respondents possessed some form of pre-payment insurance card. The majority possessed the CAM card (20%), followed by the MFP card (9%) and few respondents reported possessing the Boin de soins (0.4%). However this is not surprising given the target groups of the different cards.

- Insurance coverage is proportionally higher in Mwaro (39%) and Muramvya (31%) compared to Gitega where seventy-eight percent of respondents claim they do not possess any form of pre-payment card. This difference is consistent for the proportion of respondents in possession of CAM cards. The possession of MFP cards also differs significantly across provinces, though both Gitega (5%) and Muramvya (7%) have proportionally fewer respondents possessing MFP cards compared to Mwaro (13%). Furthermore, respondents from wealthier socio-economic groups more often reported possessing pre-payment insurance than respondents from households in poor groups. This is true for all types of insurance, though there is a greater income gradient in the proportion of respondents possessing MFP cards compared to CAM cards (i.e. the proportion of respondents possessing MFP cards increases at a greater rate across quintile groups than the proportion of respondents possessing CAM cards). Coverage also differed among age groups with the very young (<5) and very old (>50) being more likely, than other age groups, to be covered by either of the two schemes.

- The major reason for not possessing any pre-payment card was that the respondent classed themselves as either under the age of 18 or a student. This is particularly interesting given that none of the schemes exempt students or minors Significantly, proportionally more respondents from poorer households (26%) reported not being able to afford the pre-payment card. This also varies significantly across provinces, with proportionally more respondents from Gitega (28%) and Mwaro (22%),

citing their inability to afford a card as a reason for not possessing pre-payment insurance. Proportionally more respondents from wealthier households compared to respondents from poorer households reported that they did not find the cards useful, they were not available when they attempted to purchase one, or they had not yet purchased a card but did intend to do so.

- Only 10% of the sample was aware of the existence of an exemption scheme. Proportionally more of these were in the wealthier groups (only 4% in the poorest group were aware of the scheme). Furthermore, of those aware of the scheme, only 4% actually qualified for exemption and half possessed exemption papers.

- Social features of pre-payment: for those paying for health care, expenditures were highest among those groups using MFP cards. This is true over all provinces. There were no significant differences between expenditures reported by CAM cardholders and respondents who did not hold any pre-payment card. This may indicate that those with CAM cards are not getting full discount entitled too or it may be that they are receiving more expensive treatments. The proportions of total expenditure spent on drugs are lower in Muramvya than Gitega and Mwaro. However expenditures for all individuals are not zero as may have been expected (since they are subsidised 100% in Muramvya). This indicates either, individuals are still being charged for drugs or are purchasing drugs from elsewhere where they cannot use the card.

- Financial features of pre-payment: proportionally, there are significant differences in the illness rates across those groups who are covered by some form of pre-payment scheme (CAM or MFP) and those who reported not possessing any form of pre-payment insurance card. Illness rates are significantly higher among this latter group (18%) as compared to the rate reported among pre-payment cardholders (13%). Further, there is no significant difference between the illness rates reported across CAM cardholders (14%) and MFP cardholders (12%). Adverse selection among individuals therefore does not appear to be a problem. Rates of seeking care were reported to be significantly higher among those groups who are covered by some form of pre-payment scheme (87%) compared to those not possessing any pre-payment card (79%). There are, however, no differences between the proportion of respondents seeking care with CAM (85%) and MFP (93%) cards. Assuming that illness severity is equal across the groups, there is evidence that respondents in possession of a pre-payment card are more likely to utilise health services than those who do not own a card. This suggests that moral hazard may be a problem, though it is more realistic to conclude that since health care seeking rates are still comparatively low compared to other low income countries, the effect of insurance on utilisation is a 'price' effect, i.e. more people are utilising the service because they can afford to.

PART FOUR: Discussion and Conclusion

A. Implications of Results

The evidence presented from this research indicates that the majority of people are unable to afford the high costs incurred when seeking health care. This results in inequalities in accessing and utilising health care between age and gender groups, and socio-economic and geographical areas. In summary, the current pre-payment insurance

and exemption mechanisms do little to offer protection against the impact of user fees or reduce the inequalities that result. Under the existing arrangements, the CAM card virtually acts like an entitlement card – a one off payment that allows the holder to access the services that they can afford to. Given that the poor cannot afford to purchase the card they do not receive such entitlements and thereby, utilise care more infrequently or incur debt. Furthermore, the scheme may not be financially viable. Sub-optimal levels of membership mean that there is little scope for risk-pooling, and hence insufficient funds to pay for members' services. In addition, it is subject to the affects of moral hazard, particularly 'price' moral hazard effects, and payments and reimbursements are not retained within health sector. It is difficult to see how user fees and the money raised through the sale of CAM cards is effectively fed back into system. Figures based on the current system, where any revenue generated is handled by the commune administration, indicate that the public health centres retain only 1% of user fees collected. Facilities may view cost-recovery on user charges as the only means by which to keep to the service running, thereby encouraging the risk of in-effective use of services (promotion of more expensive services), and deterring access for poorer groups.

B. Conclusion

The government and donors need to look at alternative financing options within a wider, comprehensive health care financing sector strategy, focussing on how fees can be more equitable or pro-poor. Actions need to include:

- increasing public funding for the health sector
- reducing to user and drug charges to 'affordable' levels
- investing in alternative sources of funding through risk-pooling and health insurance initiatives
- focusing on equitable provision of health care
- introduce effective exemption mechanisms and explore the advantages and feasibility of introducing additional economic safety-nets (micro-finance schemes and credit associations).

As a starting point, given the existence of the CAM scheme, it would seem superfluous to establish a new system, rather the current scheme can be re-orientated. Issues that will need to be addressed include: how the insurance scheme will be managed and administered, how communities be empowered via the scheme, what people are able and willing to pay for; how central government will contribute, and what they will contribute (finance, HR, legislation, regulation, training).

IV. OVERVIEW

The study presented in this report emerged from previous work carried out by Save the Children, UK (SC UK) in Burundi, outlining the problems regarding current health reforms and the potential impact of cost recovery schemes (through raising user fees/charges at the point of service and pre-payment) (Råberg. M and Jeene. H, 2002).

Currently health care finance is raised through pre-payment schemes, voluntary for the informal sectors and compulsory (through monthly deductions from salary) for civil service employees. The success of these schemes in both raising sufficient revenue and use of revenue collected has been questioned (Råberg. M and Jeene. H, 2002). As an alternative, cost recovery schemes, through raised user charges paid at the point of service use, are being piloted in Gitega and Mwaro provinces, and have been adopted in various formats in other provinces. The aim of the government however, is to implement a countrywide cost recovery scheme – a strategy whereby communities, both through user charges and pre-payment schemes, finance the health care system.

The prevailing concern is that cost recovery is being promoted in order to raise finance for public health care provision at the expense of neglecting other health policy objectives, such as providing affordable and good quality care to all those who need it. It is feared that rising user charges will discourage vulnerable groups from seeking health care, and in cases where health care is sought, the costs will significantly impact on low income households whose standard of living is already diminished.

There is a lack of data and evidence to support *or* refute the concerns outlined above that the community *cannot* cope with the hypothesised negative impacts of cost recovery schemes or, indeed, to support the idea that adequate finance can be raised and sustained through these cost-recovery schemes in this health care system.

The broad aim of this piece of research is to evaluate the impact of the financial costs on health seeking behaviour, and the households' behaviour and ability to cope with the burden of health care costs, in order to assess the extent to which the communities of Gitega, Mwaro and Muramvya have been coping with community financing; to determine the sustainability of community financing; and, where appropriate, to identify alternative options.

The rest of this report is set out in the following sections:

- **Part one**: sets out the political and health situation and provides some background to Burundi and the context within which this study was undertaken
- **Part two**: sets out the aims, objectives and hypotheses for the study
- **Part three**: presents the main research findings
- **Part four**: discusses the results with reference to the research objectives and concludes by highlighting the next steps and possible future strategies, drawing on examples from the region.

PART ONE:

INTRODUCTION AND BACKGROUND

Part one sets out the political and health situation and provides some background to Burundi and the context within which this study was undertaken.

A. INTRODUCTION

Bordering Rwanda, Tanzania, and the Democratic Republic of The Congo (Figure 1), Burundi is the second most densely populated country in Africa, with an estimated population of 6.8 million in 2001, growing to 7,036,178 in 2002 (World Bank[a]). The central plateau is very fertile and nearly half the population live in the provinces of Gitega, Ngozi, Kayanza, Muramvya, Mwaro and Rural Bujumbura. Forced migration through civil conflict, a worsening economy, and falling food production has, however, altered this profile, with increasing numbers moving to urban areas within safe provinces.

Figure 1. Map of Burundi.

Burundi has been undergoing civil conflict since 1993 when an attempt to introduce democratic civilian rule was impeded by a military coup. In 1996 neighbouring countries imposed economic sanctions after the coup leaders abolished the national constitution, suspended the national assembly and prohibited political parties. A domestic peace process aimed at settling the crisis led to a new constitutional act and saw a new government come to power in 1998. External peace processes contributed to the agreement of a cease-fire later that year and sanctions were suspended in 1999. A

transitional multi-party government was installed in 2001, which, it was hoped, would sustain the cease-fire.

The security situation, though not resolved, has become more stable. It is clear, however that uncertainty about the economic situation has affected household livelihoods and the economy as a whole. The impact of the conflict has resulted in the displacement of large numbers of the population both inside Burundi and into neighbouring countries. It is estimated that Burundi's mainly subsistence economy has contracted by twenty-five percent during the years of conflict, and the headcount of poor increased by eighty percent in rural areas and more than doubled in urban areas over this period (World Bank[b]).

More than five years of conflict and two years of economic sanctions imposed by neighbouring states have crippled the economy, worsened social indicators, and limited access to basic social and health services.

B. HEALTH SECTOR

The Ministry of (Public) Health (MoH), as set out in decree number 100/41 of December 2001, has the responsibility to develop and implement the Government's Health Policy to ensure improvements in the health and quality of life of the population and to enable them to have a safe and productive life. To achieve this end, the Ministry is organised into services at a central level - Minister's Office, Public Health inspectorate, Public Health Directorate -, autonomous and semi-autonomous structures - including Provincial Hospitals, blood transfusion Centre, Health and Population department, and The Public Health National Institute - and decentralised structures and services - seventeen provincial health offices and health management teams. Health care delivery is undertaken through the 500 health centres and 35 hospitals[1].

The decentralised structure was driven by the structural adjustment programme (SAP) approach that was promoted by the International Monetary Fund (IMF) and the World Bank and adopted by many governments throughout much of sub-Saharan Africa during the 1980's. In 1988, the Ministry of Health of Burundi adopted a health sector decentralisation and reforms policy, although the constituent policy objectives put forward did not take hold in earnest until 1999. The policy aimed to:

- Increase community contributions to the provision of health services in their communes through the introduction of user fees.
- Gradually implement a cost recovery scheme in all health facilities.
- Harmonise the management structures of provincial health offices.
- Reduce bureaucratic decision making structures.
- Establish an autonomous management structure for health care delivery at provincial level.
- Create structures at the local level to facilitate dialogue and greater collaboration and partnership between the provincial health management team and the communities.

[1] Of the 500 health centres, 60% are public, 30% private non-profit making, and 10% are private profit making. Of the 35 hospitals, 27 are classed as first reference hospitals, 4 are second reference hospitals and 4 are National (tertiary) reference hospitals.

However, a lack of funding for health services has plagued the decentralisation process and, as a consequence, affected the provision of health care services. In real terms, the total annual public sector budget, and hence, spending in the social sector, has been shrinking year on year (the total annual public sector budget decreased from US$1,241.1 million in 1998 to US$ 1,145.1 million in 2001 (Ministère des Finances, 2001)). External aid makes up a significant proportion of this budget[2]. The health and education sectors receive the smallest allocation of funding compared to all government departments[3] and are hampered by repayment of debt, which accounts for seventeen percent of national annual expenditure (Råberg. M and Jeene. H, 2002). There has been a decrease in the percentage of total government annual expenditure allocated to health (from 5% in 1999 to 2.2% for 2003)[4]. . This equates to US$2.1 per-capita public spending on health care in 1999, falling to US$0.7 for 2003[5].

In addition to the problems caused by a decline in the economy, reductions in donor funding[6] and aid[7] have meant that the Ministry of Health's ability to provide even basic health services has been impeded.

C. COST RECOVERY

In order to promote the 1978 Alma Ata declaration "Health for All by the Year 2000", health services in Burundi before the 1980's were free at the point of delivery. However, the inability of the Government to sustain basic health services due to lack of financial resources has led to the introduction of user-fees (service charge payments) for the purposes of cost-recovery.

In October 1999, a joint memo from the Ministry of Public Health and Ministry of Finance was circulated to all provincial governors and health centres to announce the modification of pre-payment schemes and the introduction of fees at the point of delivery for all services at public health facilities (details are outlined in Box 1). The principal goal of this policy decision was to solve the numerous financial and management problems noted in various public health facilities and provincial health

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[2] External aid accounts for 56% of total expenditure on health (44% state).

[3] Whilst the percentage of government expenditure to the health sector decreased, percentage increase in expenditure between 1999 and 2003 were evident in other sectors (Parliament = 260%, Dept. Finance = 111%, Education = 86%, Justice = 78%) (The Ministry of Health, Director General, personal communication, 2003).

[4] The Ministry of Health, Director General, personal communication, 2003

[5] This compares to the levels pf per-capita spending recommended by the WHO of between US$30 and $40 (WHO, 2002).

[6] The total net flow in aid from OECD countries to Burundi were estimated to be US$131 million in 2001: http://www.oecd.org

[7] Aid per-capita was estimated to be US$14 in the year 2000 (World Bank[a]) which increased to around US$19 in 2001 (http://www.oecd.org and World Bank[a]). However, on average, only 6% (US$5.9 million) of total overseas development assistance (ODA) given to Burundi over the period 1998-2000, was spent on or directed for health programmes. This equates to US$0.9 per-capita in ODA to the health sector (http://www.oecd.org).

management structures following decentralisation and, at the same time, facilitate the improvement of quality.

Following the introduction of user charges, in January 2002, another memorandum was released from the office of the Minister of Public Health indicating the receipt of funds from the World Bank as part of the *Credit d'urgence de rehabilitation* (CURE) Project and requesting all provincial health management teams to commence a countywide "cost-recovery" scheme. However, a comprehensive strategy for this undertaking appears to be not yet present.

Box 1. Details of pre-payment insurance schemes, user fees and exemptions.

- **Pre-payment scheme**: *Three types of pre-paid insurance cards currently exist:*

Carte d'assurance Maladie (CAM): *The CAM as a national insurance scheme has existed in Burundi since 1994. Prior to the 1999 memo, the CAM was purchased by households (as opposed to individuals) and the holder was entitled to free care at the point of use[8]. Today, every individual (from age zero upward)[9] is expected to pay US$ 0.7 (500FBU) for the cost of an insurance card per year. It has been estimated that approximately 10% of the total population of Burundi posses a CAM card. Community members pay the commune administrator.*

Carte de la Mutuelle (MFP): *All public sector employees are covered by the MFP card which is paid for by deducting the equivalent of 5% from their monthly salary through the Ministry of Public Function.*

These cards function in similar ways. The purchase of these cards entitles the cardholder to an 80% discount on all services (including drug sales) at the health facility except for the consultation fee (US$0.05), which is compulsory for all at the point of service. The CAM is only accepted at government public facilities and is not accepted at non-government facilities such as missionary and private clinics and hospitals. The MFP is accepted in missionary facilities (hospitals), public hospitals, and selected pharmacies, not at public or missionary health centres. The proceeds from the sale of CAM insurance cards are retained at the commune level (lowest administration level) and are expected to fund recurrent health expenditures. However there is evidence that the money is being used for other community and management needs outside the health sector[10] [11]. Furthermore, neither the provincial health management team nor the health committees have any rights over these funds. The revenue generated from MFP cards is utilised by the Ministry of Public Function yet it is not clear how this money is re-allocated to health care.

Bon de Soins: *This is a form of private insurance available only to private sector employees. In some cases Donors and NGO's issue this card to their national staff. The costs of this insurance and use of the revenue generated from the sales of the insurance are not known.*

- ***Point of service payment****: In addition to the consultation fee, all non-card holders (all ages) pay for the total cost of all drugs and other services. Only immunisations and treatment of Tuberculosis are free[12]. A tariff was provided for all drugs and services at these facilities (though these are not evident in practice: see evidence presented below). Payments are made to a cashier at the health facility. Part of the fund is used to pay for support staff and the rest paid into a fixed account in a bank (though it is not clear what happens to this money once it has been deposited. However, the Provincial Health Teams have some control over this before the money is deposited.*

- ***Exemptions****: Although there are no clear criteria in the circulated government memo on exemption mechanisms, the office of communal administration is charged with the issuance of exemption certificates.*

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[8] Arhin, 1994.

[10] In 1990 8% of the revenues of communes in Muyinga Province came from the sale of CAM cards, whereas an average of only 1% of the commune's revenues were used to finance health care (Mcpake. B, Hanson. K, Mills. A, 1992).

[11] Reviews of pre-payment schemes, user fees and exemption policies in Råberg. M and Jeene. H, 2002, page 35.

[12] In addition, where there is considered to be health crisis (be it an epidemic or mass population movements resulting from insecurity), the Provincial Health Team and Provincial Governor may agree to offer free health care services to the populations at risk.

Lack of a coherent policy and established infrastructure to support a national cost-recovery scheme has been met with unease by some INGO's. The implementation of cost recovery schemes has been varied across provinces and has largely been dependent upon the level of NGO support and the capacity of the Provincial Health Teams. SC UK has supported the Provincial Health Teams in the provinces of Gitega and Mwaro to introduce a cost recovery scheme. At the time this work was undertaken, in addition to public funding from the government, public health centres in the provinces of Gitega and Mwaro were provided with 100% of essential drugs, from which, in principle, 20% of the cost was recovered from CAM pre-payment cardholders, and 100% of the cost was recovered from non-cardholders. Similarly costs were recovered on all other services provided. In Muramvya, public health centres were provided, by IMC, with all essential drugs and medical equipment. In principle, all treatment was free at the point of service.

As part of recent informal investigation by SC UK (quoted in Råberg. M and Jeene. H, 2002), field research in the provinces of Gitega and Mwaro investigated the impact of the health reforms and introduction of user fees, with a view to identifying the potential problems of cost recovery focussing on how the health system could cope with the task. The main findings from this work are summarised in Box 2.

Box 2: Review of pre-payment schemes, user fees and exemption policies in Gitega and Mwaro (Råberg. M and Jeene. H, 2002).

- *"Conflict arose in decision-making as few administrative and relevant provincial administrative structures had been involved in the process. None of the health staff interviewed clearly understood the objective of the health reforms being implemented, by the MoH. Nor were they able to explain the cost recovery strategy.*
- *The actual charging of tariffs differed, even though a standardised tariff system was given for all drugs and services provided at health facilities.*
- *Lack of clear definition of the MoH policy of decentralisation, coupled with limited human and logistical resources, led to a major constraint in co-ordination and management of resources."*

Recovering costs:

- *"there are no clear financial management and expenditure procedures, the revenue collected and expenditures are determined by the provincial health management teams.*
- *Revenues collected from pre-payment schemes are not utilised by the health sector, nor are the communities involved in its management."*

Formally, the success of the current attempt at cost recovery has not yet been properly evaluated. Although some of the points made above cannot be generalised to other provinces, clearly concerns over the management of the system and the impact that charging higher prices at government facilities has on the ability of poorer groups, women and children, to access necessary care, have been raised. Already it has been noted that access to health services for much of the population has been restricted. Additional constraints on seeking care include the seasonal availability of cash and the absence of social and economic safety nets.

Moreover, the prevailing concern is that cost recovery is being promoted in order to raise finance for public health care provision at the expense of neglecting other health policy objectives, such as providing affordable and good quality care to all those who need it. In other words, it is feared that rising user charges will discourage vulnerable groups from seeking health care and, in cases where health care is sought, the costs will significantly impact on low income households whose standard of living is already diminished.

However, there is a lack of robust quantitative data examining how individuals and households cope with the costs of care and, hence, whether the governments strategy of funding health care through community financed cost recovery schemes (user fees at the point of service and pre-payment insurance) is realistic and sustainable.

PART TWO:

STUDY RATIONALE

There is a clear need for data and evidence to either support or refute the concerns outlined above: that the community *cannot* cope with the hypothesised negative impacts of cost recovery schemes (through increased user charges and pre-payment schemes), and to support the idea that adequate finance can be raised and sustained through a cost-recovery scheme in this health care system.

The following section sets out the aims, objectives and hypotheses of the study from which the results in part three follow.

A. AIMS AND OBJECTIVES

The principal purpose of the study is to examine the feasibility of introducing community health-financing scheme in three rural provinces in Burundi. To this end, the objective is to provide evidence-based information on the feasibility and an appropriate framework for the introduction of a community health-financing scheme by:

1. Evaluating the impact of: (a) financial costs of illness and (b) the time costs of seeking treatment on poor household's ability to pay for care and children's access to services.
2. Evaluating the implications of (a) financial costs of illness, and (b) production or wage losses due to illness on household livelihoods (assets, debts, and social obligations).
3. Evaluating the impact of any new cost recovery policies on household ability to pay for health care and children's access to health services.
4. Evaluating the relationship between cost recovery policies and quality of health services.
5. Identifying factors that make individuals or households resilient or vulnerable when faced with illness, including (a) strengths and weaknesses in health service delivery arrangements and charging and exemption schemes, (b) the role of social resources and access to credit, (c) decision-making within the household and intra-household resource allocation patterns.
6. Proposing alternative policy options that may reduce exclusion from health services for children from poor households.

In fulfilling these objectives, the following questions posed in the TOR (Annex 1) will be answered:

- *How was illness distributed over households – was it concentrated in a small proportion of households or spread quite evenly?*
- *How did treatment response vary by type of household or individual?*
- *How did treatment response vary by social / age / gender groupings? Why?*
- *Are there big differences in results between cash rich and cash poor regions?*

- *Is distance or cash availability more of a problem in some areas than others?*
- *How does cash availability within households change health care expenditure patterns?*
- *How do household assets change health care expenditure patterns? How did the poorest quartile cope compared to others, and does this suggests riskier coping strategies?*

B. HYPOTHESES

In this study the following hypotheses were investigated:

1. Geographical Access

- In peripheral or inaccessible areas, costs of transport (time and financial) are a greater barrier than costs of drugs and other medical inputs, and prevent access to public health services even when services are free.

2. Socio-economic Groups

- Children and women have less control over household resources so are less able to pay for, and so access, services than men.

- Poor households have fewer material assets and lower social resource endowments, so have fewer strategies available to cope with the costs of illness.

- In most months, poor households have no cash available for any form of treatment or illness cost, and so have to adopt cost prevention strategies (no treatment) or risky cost management strategies (alternative cheaper providers, borrow, asset depletion, draw on social resources).

C. METHODS

For the purposes of the research, a mixture of quantitative and qualitative techniques was adopted. Data were collected at the community level through a household survey, focus groups and key informant interviews. Supply side data were collected at the facility level through the facility questionnaire.

1. Description of Fieldwork

The research focused on three ***provinces*** in central Burundi selected as potential pilot sites for community financing schemes due to their relative safety and largely rural yet stable populations.

A summary of the methods adopted and data generated are described in Table 2 and Table 3 at the end of this section. Data collectors and data in-putters received training in all methods prior to data collection (the training schedule is given in Annex 2). All data collection tools were translated into both French and the local language, Kirundi.

- **Household survey**

The household survey was conducted over six weeks[13] across the full survey site. The sample size was calculated according to the following assumptions:

a) A 95 percent confidence interval (data are correct in 95 per cent of cases)

b) A sampling precision of 4 percent (sample values do not deviate from the true population values by more than 4 percent)

c) There are an average of six members per household

d) 20% of the population had reported illness in the last month[14]

e) There was likely to be a 6 percent sampling error (likely to occur during data inputting)

f) Within each province, households would be split into five socio-economic groups

A simple sample size calculation based on these assumptions would have required a minimum sample of 960 households[15]. However, to ensure a more statistically precise sample that could be used to generate statistical differences between groups, the sample size was drawn from population data gathered for each province. Population data for each of the three provinces were estimated against a normal distribution in order to calculate the number of individuals (and hence households) required to generate a sample large enough to capture any significant differences between groups (differences between provinces and socio-economic groups). Given the assumptions outlined above, the number of households sampled in each province is shown in Table1.

Table 1: Household sample

PROVINCE	n. COMMUNES		n. ZONES		n. HOUSEHOLDS	
	TOTAL	SAMPLE	TOTAL	SAMPLE	TOTAL	SAMPLE
GITEGA	11	6	33	18	111,474	530[16]
MWARO	6	6	16	16	48,469	529
MURAMVYA	5	3	14	8	49,055	529
TOTAL	**22**	**15**	**63**	**42**	**209,998**	**1,588**

[13] During the period 20/05/02 – 28/06/02

[14] A figure given by the Drs. involved in the study.

[15] Simple sample size calculation: N=Z2*P(1-P)/d2 = (1.96)2*(0.20)(0.80)/(0.04)2 = 384. In order to capture 5 socio-economic group = (384*5) 1920 individuals, across 3 provinces requires (1920*3) 5760 individuals. Assuming 6 individuals per household = (5760/6) 960 households.

[16] Since the accuracy of sample statistics increase less than proportionally with the sample size, sampling fractions are typically smaller in larger populations (Deaton. A, 2000).

For the purposes of the survey, a household was defined as a residence whose constituent members are grouped by their joint consumption. This allowed for the fact that households relying on the same income (for example) could be split over two residences within the same (small) area.

Households within each ***zone*** at each ***commune*** level within each province were sampled conditional on security. A proportional number of households (relative to the population of the province) were surveyed within each zone (for the full household list refer to Annex 3). Households were selected randomly using the 'random walk method' (fully detailed in Annex 4).

To limit the potential for response bias that may have arisen due to the time of day that the interviews were carried out (between 9am and 4pm weekdays), interviewers were asked to use calling cards and invitations. Interviewers could then arrange a specific time for the interview when all members could be present. Where possible all members of the household were interviewed. However, in some cases this was not possible: where a parent answered for young children, where another household member may have had permission to answer for an absent member, or where a household member was absent and no other member responded for them. A copy of the household survey is shown in Annex 4 and the Kirundi translation of the questions is given in Annex 5.

- **Key Informant Interviews**

In each province, interviews were conducted with the Provincial Governor, commune administrators, teachers, religious leaders and traditional birth attendants. Overall, about 42 interviews were conducted across all 3 provinces. An outline of the key informant questionnaire is set out in Annex 6.

- **Facility Questionnaire**

In each province questionnaire based interviews were carried out in public health centres, private heath centres/clinics, missionary health centres/clinics, hospitals; and with; traditional healers, and private pharmacists. In hospitals and health centres, the director, doctors, nurses, and pharmacists, where applicable and possible, were interviewed. Overall, about 45 questionnaires were conducted across all 3 provinces. An outline of the facility questionnaire is set out in Annex 7.

- **Focus Groups**

In each province, focus group discussions (FGD's) were held separately with children and adults and split into male and female groups. Where possible subjects were recruited randomly, although due to time constraints some convenient samples were also used. Overall, 12 focus groups were conducted across all 3 provinces, 4 (1 for each group) in each province. An outline of the focus group discussions is set in Annex 8.

Table 2: Summary of Methods Adopted.

APPROACH	RATIONALE
HOUSEHOLD SURVEY QUESTIONNAIRE	To provide a 'snapshot' of health seeking behaviour and generate quantitative data on: • Household socio-economic and demographic characteristics • Illness experience • Treatment strategies • Treatment costs, and coping strategies
KEY INFORMANT QUESTIONNAIRE	To provide data on the opinions of: • Those who have a significant role in the provision of health services in their community at an administration level • To interview key people (outside of health care provision) in the community who may be aware of household and community constraints in accessing and seeking health care
FACILITY QUESTIONNAIRE	To provide supply side data on: • Utilisation, revenues, charging and exemptions • Experiences and opinions on the current system
FOCUS GROUPS	To provide additional data from the community level on households': • Experience of accessing care • Seeking care • Utilising services

Table 3: Summary of data generated by methods

APPROACH	INTERVIEWEE	NUMBER /PROVINCE	DATA COLLECTED
HOUSEHOLD SURVEY QUESTIONNAIRE	Households	529/530	• Household members' characteristics • Household illness and exemptions • Utilisation of health care (all levels) • Household characteristics (income expenditure and access) • Household perceptions of health care services and household decision making
KEY INFORMANT INTERVIEWS	Commune administrator	3	• Health insurance data • Exemption policy and practice • Perceptions of service provision
	Provincial Governor	1	
	Primary school teacher	1 (public) 1 (private)	• Perceptions of service provision • Perceptions of household illness and treatment decisions
	Secondary school teacher	1 (public) 1 (private)	
	Traditional birth attendant	3	
	Religious leader	3	
FACILITY QUESTIONNAIRE	• Public Health Centre • Private Health Centre • Missionary Health Centre • Traditional healer • Private pharmacy	• 3 • 1 • 1 • 2 • 2	• Patterns of illness/diseases and treatments • Charging and exemption practice • Utilisation rates and revenues
	Hospital: • Pharmacist • Doctor • Nurse • Hospital director	• 1 • 2 • 2 • 1	• Patterns of illness/diseases and treatments • Charging and exemption practice • Utilisation rates and revenues
FOCUS GROUPS	Adult Male (>18)	1	• Patterns of illnesses and treatments • Household's health care treatment decisions • Household's constraints in accessing health care • Insurance and exemption systems • Provision and quality of health care services
	Adult Female (>18)	1	
	Child Male	1	
	Child Male	1	

PART THREE:

RESEARCH FINDINGS

a note on the results section: where possible the full results have been presented. Significance tests have been conducted on the results where possible. These have been reported at the 0.05 level unless otherwise stated. Where appropriate statistical calculations are presented in the text or incorporated into the results tables. However the results of more complex statistical calculations (ANOVA tests) have only been reported but not displayed.

This part of the report sets out the main research findings as follows: a) demographic profile; b) patterns of illness; c) health seeking behaviour; d) cost of illness; e) household coping strategies; f) cost protection and risk sharing strategies; and g) perceptions of health care system. The results discussed are primarily those from the household survey, with supporting anecdotal evidence taken from the facility questionnaires, key informant interviews, and focus group discussions.

A. DEMOGRAPHIC PROFILE

1. Sample Population

The household survey covered 1,588 households from 15 communes and 3 provinces: Gitega, Mwaro and Muramvya. After cleaning the data, responses were compiled for 1,547 households (see Table 4).

Table 4: Survey sample (n=1,588)

PROVINCE	COMMUNES	ZONES	HOUSEHOLDS SURVEYED	HOUSEHOLDS IN SAMPLE
GITEGA	6	18	530	499
MWARO	6	16	529	521
MURAMVYA	3	8	529	527
TOTAL	**15**	**42**	**1,588**	**1,547**

The response rate at the household level was high (see Table 4). The survey population covered by our sample is summarised in Table 5. Households comprised an average of 5.18 household members, of which 2.24 were over the age of 18. The average size of households differed significantly across provinces. The mean household size in Gitega (4.54) is significantly smaller (at the 0.05 significance level) than the average household size in Mwaro (5.55) and Muramvya (5.43). The average number of household members

over the age of 18 also differs significantly across provinces. The average number of household members in Gitega (2.05) is significantly smaller than the average number in Muramvya (2.25), which is significantly smaller than the average number in Mwaro (2.43).

Table 5: Survey population (n=8020)

PROVINCE	COMMUNE	NO. HOUSEHOLDS	NO. INDIVIDUALS IN SAMPLE	AVERAGE HOUSEHOLD SIZE*	NUMBER MEMBERS >18*	NO. COMPLETE INDIVIDUAL RESPONSES	INCOMPLETE OR MISSING RESPONSES, N., %
GITEGA	Giheta	96	441	4.59	2.13	438	3
	Gishubi	64	281	4.39	2.17	281	0
	Gitega	136	612	4.50	1.96	607	5
	Makebuko	82	371	4.52	1.89	368	3
	Mutaho	73	356	4.88	2.18	356	0
	Nyarusan	48	205	4.27	2.06	205	0
TOTAL		**499**	**2266**	**4.54**	**2.05**	**2255**	**11, 0.5%**
MWARO	Bisoro	70	367	5.24	2.41	366	1
	Gisozi	53	326	6.15	2.91	326	0
	Koyokwe	85	462	5.44	2.16	459	3
	Ndava	125	689	5.51	2.39	688	1
	Nyabihan	109	599	5.50	2.49	598	1
	Rusaka	79	450	5.70	2.39	449	1
TOTAL		**521**	**2893**	**5.55**	**2.43**	**2886**	**7, 0.2%**
MURAMVYA	Kiganda	178	918	5.16	2.20	739	179
	Muramvya	215	1185	5.51	2.26	918	267
	Rutegama	134	758	5.66	2.28	606	152
TOTAL		**527**	**2861**	**5.43**	**2.25**	**2263**	**598, 21%**
TOTAL		**1547**	**8020**	**5.18**	**2.24**	**7404**	**616, 8%**

* average household size calculated using all individuals belonging to a household not just those surveyed *and* responding.

The total number of individual responses to the survey after cleaning was 7,404 (see Table 5). This represents the number of complete individual responses. The completeness of data at the individual level varied across provinces with the response rates in Gitega and Mwaro calculated as 99.5% and 99.8% respectively. Muramvya had a very low level of response in comparison, with 21% of individual level data classed as missing or incomplete[17]. There is no demographic data available on non-responders, but

[17] It is not clear why there is such a large amount of missing data for Muramvya province. Errors may have occurred through data collection or data entry.

the reader should bear in mind that individual level data for Muramvya may be biased through non-response and may not be representative.

Table 6 indicates that the composition of households in all three provinces is more heavily weighted toward dependents: those who are either under the age of 15 or over the age of 50. Overall, on average fifty-eight percent of individuals within a household are classed as being dependent. Table 6 also shows the gender of the head of household, elicited in the questionnaire as the main respondent or household head. Statistically, the proportion of households headed by males only and those jointly headed (by males and females who are partnered or married) differs across provinces. Gitega has significantly more male only headed households (52%) and fewer jointly headed households (35%) compared to Mwaro and Muramvya. A small proportion of households (1.1%) are headed by women with the support of another male (a father or father in law, brother or brother in law, grandfather or other non-relative). Interestingly, in our sample, no households are singly headed by a female.

Table 6: Household dependency (n=1547)

PROVINCE	DEPENDENCY RATIO[18] (%. <15 AND >50)	HEAD OF HOUSEHOLD, N., (%)			
		Male Head	Joint Head (partners/ married)	Female Head supported by Male (other)	TOTAL* (all genders)
GITEGA	56	261, 52%	173, 35%	4, 0.8%	499
MWARO	58	217, 42%	240, 46%	8, 1.5%	521
MURAMVYA	60	197, 37%	248, 47%	5, 0.9%	527
TOTAL	**58**	**675, 44%**	**661, 43%**	**17, 1.1%**	**1,547**

* including missing values: head of household where gender value missing

The age-gender distribution of the responding population, summarised in Table 7, illustrates that the dependent population is mainly comprised of young children, with fifty percent of the population being under fifteen. The gender ratio favours women in all age groups except the very young and old. This pattern is constant across all provinces. The profile of the sample is similar to UNDP estimates for the country from 1999 (UNDP 2001).

It was thought that ethnicity was too sensitive a question to ask in the household survey; instead respondents were asked what they considered to be their migration status in Burundi. Ninety-seven percent claimed they were permanent residents, as opposed to being displaced from elsewhere within Burundi, or a refugee. This is surprising given the large numbers of people that have been displaced within Burundi (an estimated 600,000

[18] The dependency ratio is the total number of dependents in a household (classed as those under fifteen years of age and those over fifty years of age) as a percentage of the total number of household members. A percentage of over 50 indicates that there are more dependents in the household than other, non-dependent, members.

Burundians were believed to be internally displaced in 2001, 380,000 at displacement sites and around 200,000 living with friends, families, or on their own (USCR, 2001)[19].

Table 7: Age and gender distribution of sample population (n=7404)

AGE GROUP	MALE	FEMALE	GENDER RATIO (FEMALE:MALE)	TOTAL	PERCENT OF POPULATION
<5	578	560	0.97	1205	16%
6-15	1107	1250	1.13	2521	34%
16-30	638	942	1.48	1669	23%
31-50	543	755	1.39	1368	18%
>50	274	262	0.96	579	8%
ALL AGES*	**3166**	**3800**	**1.2**	**7404**	**100%**

* including missing values on gender

2. Livelihoods

The majority of the sample reported that they work all year (3199, 43%) (see Table 8) and a large proportion are pupils or students (1,828, 25%). It is clear, however, that not all young people are in education (compare Tables 7 and 8). 1,828 pupils and students, represents seventy-two percent of the age group 6-15 population in the sample (Table 7)[20].

The pattern of employment status differs significantly across provinces, i.e. the hypothesis that there is no association between province and employment status is rejected. There is also a significant association between employment status and gender, with higher proportions of women (47%) working all year and proportionally more men (5%) engaged in 'other' forms of employment.

From these results it appears that unemployment is virtually non-existent. A total of 3,766, fifty-one percent, respondents are engaged in some form of employment (be it all year, seasonally, occasionally, or 'other') and another 2,047, twenty-eight percent, are in education or are pre-school. Only 68, one-percent, were classed as being unemployed or had no capacity to work. However, a high proportion of respondents, 1523, twenty percent (23% of males and 19% of females), failed to answer this question or were unsure of how to classify their employment status. This may actually reflect those that are unemployed but did not wish to disclose it to the interviewer. Furthermore, underemployment may be a more common phenomenon than unemployment. Seasonal, occasional or 'other' types of employment may represent those proportions of respondents that are unable to gain full-time employment.

[19] However, communes known to contain large numbers of IDPs (Bukeye and Mbuye in Muramvya) were not surveyed (for either security or access reasons).

[20] Primary education enrolment was estimated to have been 44% in 1999 (World Bank[a]). This is similar to rates recorded for other central African countries (Filmer. D and Pritchett. L, 1999).

Table 8: Employment Status (n=7404)

	PROVINCE						TOTAL		
	GITEGA		MWARO		MURAMVYA				
	N	%	N	%	N	%	N	% M	% F
Pre-school; child	94	4	97	3	28	1.2	219	3	3
Pupil or student	431	19	827	29	570	25	1828	25	24
Works all year	1121	50	1159	40	919	41	3199	38.5	47
Works Seasonally	27	1	20	1	6	0.3	53	0.6	1.0
Works Occasionally	10	0.4	16	0.6	14	0.6	40	0.8	0.3
Other	249	11	188	6	37	1.6	474	8	5
No capacity to work	15	0.6	33	1	7	0.3	55	0.7	0.7
Unemployed	1	-	11	0.4	1	-	13	0.4	0
Unsure / missing	307	14	535	19	681	30	1523	23	19
TOTAL	**2255**	**100**	**2886**	**100**	**2263**	**100**	**7404**	**100**	**100**

Of those in some form of employment (3,766), eighty percent work primarily as subsistence farmers on their own or on rented land (see Table 9).

Table 9: Type of Employment and reimbursement (n=3766)

	GITEGA			MWARO			MURAMVYA			TOTAL
	M, N, %	F, N, %		M, N, %	F, N, %		M, N, %	F, N, %		N, %
Agricultural (own land)	381, 65%	545, 73%	984, 70%	412, 71%	606, 85%	1086, 78%	297, 82%	529, 91%	858, 88%	**2928, 77%**
Agricultural (other incl. Rented)	22, 4%	32, 4%	55, 4%	9, 2.5%	10, 1.4%	22, 1.6%	8, 2%	17, 3%	25, 3%	**102, 3%**
Civil service	12, 2%	14, 2%	31, 2%	37, 6%	14, 2%	52, 4%	15, 4%	7, 1.2%	22, 2%	**105, 3%**
Skilled manual	4, 1%	2, 0.5%	6, 0.5%	3, 0.5%	1, 0.1%	5, 0.4%	4, 1%	1, 0.2%	5, 1%	**16, 0.5%**
Household/ domestic	9, 1%	3, 0.5%	15, 1%	25, 4%	11, 1.5%	37, 3%	12, 3%	7, 1.2%	20, 2%	**72, 2%**
Other (incl. Handicrafts, sales)	80, 14%	71, 10%	159, 11.5%	71, 12%	56, 8%	137, 10%	16, 5%	7, 1.2%	23, 2%	**319, 8.5%**
Missing	74, 13%	75' 10%	157, 11%	23, 4%	17, 2%	44, 3%	10, 3%	12, 2.2%	23, 2%	**224, 6%**
SIG (M/F split)	0.015			0.001			0.001			
TOTAL	**582 (100)**	**742 (100)**	**1407 (100)**	**580 (100)**	**713 (100)**	**1383 (100)**	**362 (100)**	**580 (100)**	**976 (100)**	**3766 (100)**
SIG (provinces)	0.001									

Table 9: continued

REMUNERATION			
	CASH	**OTHER**	**TOTAL**
Agricultural (own land)	117 (4%)	2811 (96%)	**2928 (100)**
Agricultural (other incl. Rented)	14 (14%)	88 (86%)	**102 (100)**
Civil service	101 (96%)	4 (4%)	**105 (100)**
Skilled manual	11 (69%)	5 (31%)	**16 (100)**
Household/ domestic	56 (78%)	16 (22%)	**72 (100)**
Other (incl. Handicrafts, sales)	73 (23%)	246 (77%)	**319 (100)**
Missing	7 (3%)	217 (97%)	**224 (100)**
TOTAL	**379 (10%)**	**3387 (90%)**	**3766 (100)**

Most of these people (96% who work their own land and 86% who work on rented land) receive some other form of remuneration than money. The type of employment differs significantly across provinces. Respondents in Muramvya are more likely (88%) to own their own land and less likely to undertake other types of employment compared to Gitega and Mwaro. The type of employment also varies significantly between males and females in all provinces. In all cases women are more likely to be working on their own land whilst men are more likely than women to undertake work in the civil service, skilled manual jobs, domestic jobs and 'other' types of work. What is clear is that a large proportion of employment is undertaken within the informal employment sector – largely, agricultural work where cash remuneration is uncommon.
For the 3,834 respondents that have completed their education, (i.e. those who are not currently pre-school, 219, are no longer students, 1,828 and omitting the missing values, 1,523), final education status is summarised in Table 10.

Twenty percent of the sample received no formal education. Education status differs significantly across provinces. There are significant associations between provinces and the proportions of educated respondents compared to non-educated respondents. Gitega has a significantly larger proportion of respondents who have received no formal education (35%) compared to Mwaro (16%) and Muramvya (3%), which have a significantly smaller proportion. Moreover, in Gitega the proportion of respondents who have received no formal education differs significantly between men and women, with more male respondents (39%) compared to female respondents (33%) having no education.

Proportions of respondents receiving other forms of education, including missionary teaching and training in technical skills, vary across provinces and may depend on the location of schools and institutions.

Table 10: Status upon leaving education (n=3,834)

PROVINCE	GITEGA		MWARO		MURAMVYA[21]		TOTAL*
	M	F	M	F	M	F	
NO EDUCATION	227 (39%)	244 (33%)	96 (16%)	124 (17%)	7 (2%)	17 (3%)	**752 (20%)**
TOTAL*	498 (35%)		229 (16%)		25 (3%)		**SIG 0.001**
<= PRIMARY EDUCATION	88 (15%)	98 (13%)	140 (23%)	126 (17%)	89 (24%)	148 (25%)	**741 (19%)**
SECONDARY EDUCATION >	19 (3%)	17 (2%)	36 (6%)	13 (2%)	13 (4%)	17 (3%)	**123 (3%)**
OTHER[22]	130 (22%)	264 (35%)	177 (30%)	321 (44%)	4 (1%)	9 (2%)	**971 (25%)**
UNKNOWN / DON'T KNOW	124 (21%)	126 (17%)	153 (25%)	145 (20%)	255 (69%)	391 (67%)	**1247 (33%)**
TOTAL (GENDER SPLIT)	**588**	**749**	**602**	**729**	**368**	**582**	**3618**
TOTAL*	**1423**		**1427**		**984**		**3834**

* including missing values on gender

3. Household Socio-economic Status

For analytical purposes, households were categorised into socio-economic groups on the basis of their patterns of consumption behaviour, as elicited through the household survey[23]. Consumption was calculated from household spending on education, food, fuel, health care, and other outgoings such as providing monetary support to relatives and paying loans.

Table 11 illustrates the division of the consumption groups into five quintile categories: poor, below average, average, above average and rich[24]. Data on consumption was missing for 265 households (17% of the household sample). The remaining 1,282 households with complete consumption data are used to disaggregate analysis by socio-economic status where appropriate.

[21] It should be noted that there is large amount of missing data on education status for Muramvya province. 67% of respondents (including those with missing values on gender) were unclear of their education status or refused to answer the question (this compares to 18% in Gitega and 22% in Mwaro). This may represent those respondents who had poor education status or errors in data collection.

[22] Missionary, technical teaching

[23] The accuracy of estimates of consumption values are variable and are likely to underestimate true consumption patterns. Respondents may have had difficulty understanding the task that was asked of them, may have been unable to apply monetary values to all consumption goods, and may not have been able to recall these estimates accurately.

[24] These categories do not denote absolute values of poverty or wealth but are constructed relative to one another. Consequently rich households in this survey are still considered to be absolutely poor in relation to global comparisons, but are wealthier than the very poorest households covered in this survey and therefore rich in comparison.

Table 11: Socio-economic grouping (n=1,282)

QUINTILE[25]	POOR	LOWER AVERAGE	AVERAGE	UPPER AVERAGE	RICH	GROUP TOTAL
Consumption Range (BIF)	Less than 8,516	8517-16,245	16,246-28,635	28,636-54,137	Greater than 54,137	**n/a**
Average annual per-capita consumption	4,728	12,392	21,640	38,295	129,952	**38,013**
Percent of households in each group by province						
GITEGA	38	24	16	8	14	**100**
MWARO	13	19	22	23	23	**100**
MURAMVYA	11	18	21	27	23	**100**
TOTAL HOUSEHOLDS	**257**	**256**	**256**	**257**	**256**	**1,282 of 1,547**
TOTAL (n) INDIVIDUALS	**1322**	**1387**	**1249**	**1169**	**1084**	**6,211 of 7,404**

The proportion of households within each quintile group differs significantly across provinces. Gitega has a significantly larger proportion of households in the poorer quintiles (38% and 24%) compared to Mwaro and Muramvya, which do not differ significantly and have larger proportions of households in the wealthier quintiles (also see Figure 2)[26].

On average, annual per-capita consumption is calculated to be 38,013BIF (45 USD[27]). Over sixty percent of households (1,026, the proportion of households in the 3 lowest quintile groups) are living on less than US$1 a day[28].

However, it is clearly evident from the existing analysis that cash availability is extremely limited in these areas of Burundi. For a large proportion of households, the main source of income is earned through subsistence farming and cultivating their own land, and not generated from a cash source. The average BIF consumption values are therefore likely to be lower than *actual* consumption values due to households consuming food cultivated from their land, though an estimate of this was not elicited in the household survey.

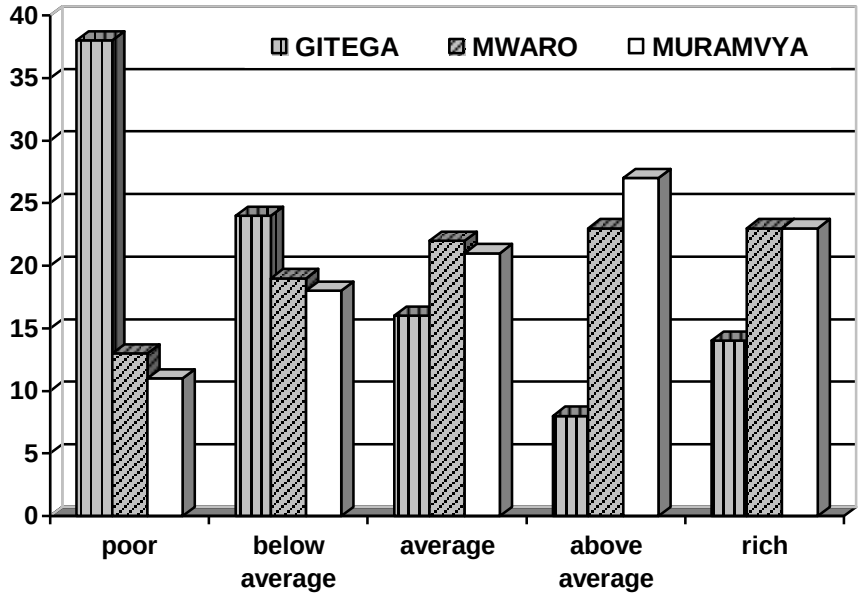
[25] Currency conversion 1USD = 843.670 BIF. According to rate on 01 June 2002 (time of the survey).

[26] This may not be representative of these provinces due to difficulties in sampling areas where security could not be guaranteed. It may be that these areas are more rural, vulnerable and poor.

[27] Currency conversion 1USD = 843.670 BIF. According to rate on 01 June 2002 (time of the survey).

[28] The proportion of the population living in extreme poverty (proportion of population below $1 a day) was recorded as 36.2% in 1999 (World Bank[c]) (though these estimates included the urban populations of Bujumbura).

Figure 2: Distribution of socio-economic groups by area (n=1,282)



In order to validate the use of household consumption quintile groups in further analysis, the significance of the quintile groups correlated with other socio-economic indicators was assessed. The indicators used were: individual level education status (upon leaving education), education status of the head of the household (upon leaving education), and an asset count[29]. The association and significance of the quintile categories correlated with the other socio-economic indicators is shown in Table 12.

Individual education status and head of household education status are both significantly associated with quintile level. These associations and the association of asset count are significantly[30] linearly correlated[31] and would appear to support the use of the quintiles in categorising responses into socio-economic groups in the following analyses.

[29] The household survey collected data on the types and quantities of assets owned by households but these were not valued. For the purposes of validating the quintile groups, the assets are not assigned an implicit value but are simply added across households. Wealthier groups, as well as owning more valuable assets, are also likely to own more assets per se, and vice versa.

[30] A significance level of <0.05 indicates that the groups are significantly correlated with an accuracy of 95%. A significance level of <0.01 indicates that the groups are significantly correlated with an accuracy of 99%.

[31] i.e. education level and asset count are positively significantly correlated with quintile group: as quintile group increases so does education status and asset count. Members of higher quintile groups are more likely to be educated as opposed to not educated, and to own more assets.

Table 12: Validation of socio-economic groups (n=1,282)

QUINTILE VALIDATION (n)		POOR	LOWER AVERAGE	AVERAGE	UPPER AVERAGE	RICH	GROUP TOTAL	SIGNIFICANCE
INDIVIDUAL LEVEL EDUCATION	None	243	142	80	75	60	600	0.001
	Primary only or lower	107	128	155	118	128	636	
	Secondary >	6	9	13	26	63	117	
HEAD OF HOUSEHOLD EDUCATION LEVEL	None	65	43	35	30	23	196	0.001
	Primary or lower	37	50	50	51	57	245	
	Secondary >	3	5	6	11	35	60	
ASSET COUNT	Total number of assets	543	919	1079	1021	1247	4809	0.001
TOTAL (n) HOUSEHOLDS		257	256	256	257	256	**1,282 of 1,547**	

4. Other Findings

Selected findings from focus group discussions, facility and key informant interviews and qualitative extracts from the household questionnaire:

- Generally men and women have different roles within the household but tend to have equal decision-making power. However it was noted that: "*people are different, some people have different husbands who don't care about family problems, he wanders and abandons his wife, but a woman can't abandon her child*"
- Men tend to have control over the money that they earn.
- Many families in Burundi are regarded as being very poor, especially those from rural areas.

5. Summary

- *Household size varied significantly between provinces. The total number of household members (4.54) and the number of members over 18 (2.05) were smaller in Gitega. However, household dependency does not vary between provinces (average 58%).*
- *There is evidence that males and females have more or less equal decision-making power in the household. A large proportion of households are jointly headed by couples (43%). This is also evident in the FGD's. On the other hand, Gitega differs significantly, in that proportionally more households are male only headed (52%).*

- *Population statistics are similar to those for the region: 50% are under 16. Females dominate between the ages of 6 and 50. This may be as a result of male casualties or absence due to the conflict.*

- *For those respondents that have completed their education, 20% received no formal education. Gitega has significantly more respondents with no formal education more of these being males. 28% of respondents reported currently being in education (72% of the 6-15 age group sample). Primary education enrolment for Burundi was estimated to have been 44% in 1999 (World Bank[a]). This is similar to rates recorded for other central African countries (Filmer. D and Pritchett. L, 1999).*

- *A large proportion of respondents work all year (43%), 80% of these work as subsistence farmers on family owned or on rented land. Higher proportions of women in all provinces work the land whilst men are more likely to have other jobs.*

- *Cash availability is low. Only 10% of respondents who work receive cash remuneration for employment undertaken. Average per-capita consumption is 38,013BIF (45USD) and consumption levels in over 60% of households are under the $1 a day level. This compares to the proportion of the population living in extreme poverty in Burundi (proportion of population below $1 a day) recorded as 36.2% in 1999 (World Bank[c]). Gitega has significantly larger proportions households in poorer groups. Though evidently even those in 'wealthier groups' are classed as being poor.*

B. PATTERNS OF ILLNESS

a note on definitions used: the following definitions are used in subsequent sections:

- **Long standing illness:** an illness that is either classed as chronic (by the respondent) or is recurrent. This includes any medical condition that has troubled them over time, or that is likely to continue to affect them for a period of time of say a year.
- **Illness in last 6 months:** whether the individual responding has either been ill, suffered an injury, or had a condition which required medical attention (external or domestic) within the six months prior to the survey. This includes all those below who were ill 4 weeks prior to the survey.
- **Illness 4 weeks prior to survey:** whether the individual responding has either been ill, suffered an injury, or had a condition which required medical attention (external or domestic) within the four weeks prior to the survey only.

  ****This sample is used as the recall period to elicit further information about acute illness, treatment responses and costs.****

1. Prevalence of Illness

note: prevalence rates reported here on in are calculated as a percentage the total sample surveyed: 7,404.

Of those surveyed **(7,404)**:

- **881 (12%)** suffered from a **long-standing illness**. The most commonly reported illness was Malaria (65%)[32], followed by diseases of the digestive system (or gastro-intestinal diseases) (7%). Most notably, thirteen percent of respondents reported having had an 'other' illness. This may be a result of individuals being unwilling to disclose the nature of some diseases such as STDs, HIV or AIDS which, although were presented as options in the survey, were not reported by respondents. Common diseases that carry social stigma are therefore likely to have been under reported in this survey.

- **2,192 (30%)** reported having being **ill** sometime in the **six months prior to the survey.**
- **1,189 (16%)** reported having being **ill** during the **four weeks prior to the survey date.**
- **5,212 (70%)** reported having had **no illness or refused to respond.**

[32] An important note to make here is that the type of Malaria prevalent in Burundi is not classed as a chronic illness per se. Consequently, this result may highlight the fact that either people are repeatedly infected, not being treated appropriately in the first instance, or the treatment is ineffective.

Of those that reported illness (2,192), the majority were now fully recovered and of those reporting illness in the 4 weeks prior to the survey (1,189) sixty percent said they had recovered in two weeks or less, suggesting they were reporting acute illnesses. Most commonly listed illnesses were Malaria (57%), respiratory problems (11%) and 'other' (9%).

The prevalence of illness differs significantly across provinces with Gitega reporting relatively higher illness rates (43% within the last 6 months and 20% in the 4 weeks prior to the survey) compared to Mwaro (23% within the last 6 months and 14% in the 4 weeks prior to the survey) and Muramvya (24% within the last 6 months and 15% in the 4 weeks prior to the survey) in all cases. However prevalence is not significantly associated with quintile group i.e. illness does not vary significantly across quintile groups, so this difference cannot be explained by differences in the socio-economic profile of the provinces (Table 13).

Table 13: Prevalence of illness reported across Provinces and socio-economic groups (n=7,404)

	LONGSTANDING ILLNESS	ILLNESS IN LAST 6 MONTHS	ILLNESS 4 WEEKS PRIOR TO SURVEY	TOTAL
GITEGA	390 (17%)	977 (43%)	446 (20%)	**2255**
MWARO	415 (14%)	669 (23%)	401 (14%)	**2886**
MURAMVYA	76 (3%)	546 (24%)	342 (15%)	**2263**
TOTAL	**881 (12%)**	**2192 (30%)**	**1189 (16%)**	**7404**
SIGNIFICANCE	0.01	0.01	0.01	

QUINTILE	ILLNESS 4 WEEKS PRIOR TO SURVEY	TOTAL
POOR	216 (16%)	**1322**
BELOW AVERAGE	231 (17%)	**1387**
AVERAGE	214 (17%)	**1249**
ABOVE AVERAGE	217 (19%)	**1169**
RICH	210 (19%)	**1084**
SIGNIFICANCE	0.233	

The prevalence of illness among age and gender groups is shown in Table 14. The prevalence of a long-standing illness is significantly associated with age group. A greater proportion of respondents in older age groups reported a long-standing illness (21% of males and 27% of females in the over 50 age groups) compared to respondents in younger age groups. On average, prevalence of a long-standing illness was higher among females as compared to males (over all age groups, 13% of females reported a long-standing illness compared to 10% of males). This difference was statistically significant in the 31-50 and over 50 age groups.

Table 14: Prevalence of illness across age and gender groups (n=7,404)

AGE GROUP	<5		6-15		16-30		31-50		>50		ALL AGES*	
GENDER	M	F	M	F	M	F	M	F	M	F	M	F
LONG-STANDING ILLNESS	41 (7%)	40 (7%)	81 (7%)	99 (8%)	67 (11%)	126 (13%)	74 (14%)	159 (21%)	58 (21%)	72 (27%)	**321 (10%)**	**501 (13%)**
SIGNIFICANCE	**0.532**		**0.279**		**0.057**		**0.001**		**0.045**		**0.001**	
ILLNESS 4 WEEKS PRIOR TO SURVEY	97 (17%)	109 (19%)	106 (10%)	144 (12%)	88 (14%)	161 (17%)	82 (15%)	189 (25%)	52 (19%)	80 (31%)	**427 (13%)**	**689 (18%)**
SIGNIFICANCE	**0.136**		**0.071**		**0.044**		**0.001**		**0.001**		**0.001**	
TOTAL*	**223 (19%)**		**267 (11%)**		**259 (16%)**		**286 (21%)**		**146 (25%)**		**1189 (16%)**	
POP (GENDER SPLIT)	578	560	1107	1250	638	942	543	755	274	262	**3166**	**3800**
POP (AGE SPLIT)	1205		2521		1669		1368		579		**7404***	

* including missing values on age (62) and gender (495).

The prevalence of illness 4 weeks prior to the survey was also significantly associated with age group. The prevalence of illness was lowest among the 6 to 15 year age group (only eleven percent reporting having experienced illness in the 4 weeks prior to the survey) and was highest in the over 50 age-group (twenty-five percent of those over 50 reported having experienced illness in the 4 weeks prior to the survey)[33]. Conversely, the 6-15 age group made up a large proportion (23%) of all those reporting illness in the 4 weeks prior to the survey (1,189) and those over the age of 50 constituted the smallest proportion (12%) (see Figure 3[34]).

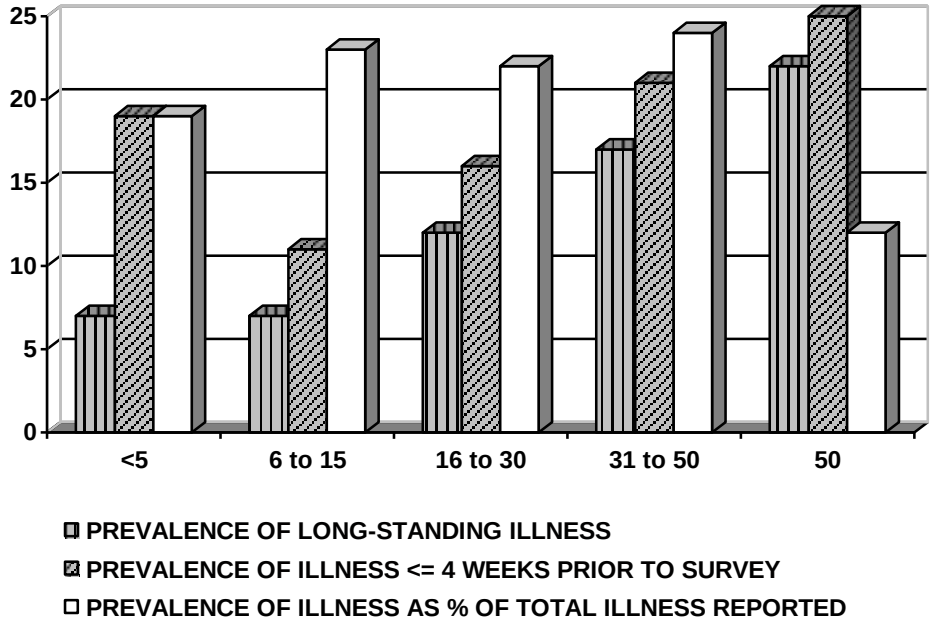
On average, more females reported having experienced illness within 4 weeks prior to the survey (over all age groups, 18% of females reported illness compared to 13% of males). This difference is evident across all age groups and is significant with 90% confidence (at the 0.10 level) in the 6-15 age groups and significant with 95% confidence in the 16-30, 31-50 and over 50 age groups.

[33] It should be noted that the prevalence of illness reported in the under 5 age-group (19%) may be underreported.

[34] Figure 3 shows:

- the percentage within each age group reporting a long-standing illness (calculated as: n(those reporting long-standing illness in each group)/n(in each age group))
- the percentage of those within each group reporting an illness within 4 weeks prior to the survey (calculated as: n(those reporting illness within 4 weeks prior to the survey within each group)/n(within each age group)), and
- the percentage of those reporting illness within 4 weeks prior to the survey by age group (calculated as: n(those reporting illness within 4 weeks prior to the survey within each age group)/n(total individuals reporting illness within 4 weeks prior to the survey over all age groups))

Figure 3: prevalence of illness reported by age group (n=7,342)



2. Household Illness

note: household illness rates are reported as a percentage of the total number of households sampled: 1,547.

Thirty-one percent of households reported having at least one household member with a long-standing illness and twelve percent had to cope with two or more members of the household having a long-standing illness (see Table 15).

Gitega and Mwaro have a significantly greater proportion of households with *at least* one household member who reported having a long-standing illness (33% and 41% respectively) compared to Muramvya where only twelve percent of households have at least one member with a long-standing illness. The burden of long-standing illness differs significantly between provinces. On average, the number of members with a long-standing illness within a household varies significantly between Muramvya (where, on average, households have 1.19 members with a long-standing illness) and Gitega and Mwaro (where, on average, households have more members with a long-standing illness, 1.99 and 1.95) respectively).

Over all households surveyed, forty-nine percent had *at least* one member who reported having been ill within the 4 weeks prior to the survey date. Gitega has a significantly higher proportion of households with at least one member reporting

illness (59% of households had at least one member who had been ill within the recall period) compared to Mwaro (49%) and Muramvya (40%).

Table 15: Burden of illness across households (n=1,547).

	LONGSTANDING ILLNESS			ILLNESS <=4 WEEKS PRIOR				TOTAL
	N of household members			N of household members				
	1	2 >	MEAN	1	2 >	NONE	MEAN	
GITEGA	114 (23%)	52 (10%)	1.99	194 (39%)	100 (20%)	205 (41%)	1.52	**499**
MWARO	120 (23%)	93 (18%)	1.95	166 (32%)	90 (17%)	265 (51%)	1.57	**521**
MURAMVYA	53 (10%)	11 (2%)	1.19	141 (26%)	73 (14%)	313 (60%)	1.60	**527**
POOR	48 (9%)	31 (12%)	1.94	92 (36%)	48 (19%)	117 (45%)	1.54	**257**
BELOW AVERAGE	37 (7%)	32 (13%)	2.12	103 (40%)	49 (19%)	104 (41%)	1.52	**256**
AVERAGE	64 (25%)	27 (11%)	1.67	98 (38%)	46 (18%)	112 (44%)	1.49	**256**
ABOVE AVERAGE	51 (20%)	28 (11%)	1.62	79 (31%)	50 (19%)	128 (50%)	1.68	**257**
RICH	49 (19%)	37 (14%)	1.84	78 (30%)	50 (20%)	128 (50%)	1.64	**256**
TOTAL	**287 (19%)**	**186 (12%)**	**1.8**	**501 (32%)**	**263 (17%)**	**783 (51%)**	**1.6**	**1547**

The burden of household illness does not, however, vary significantly between provinces. On average, all households had similar proportions of members who had reported having an illness within the 4 weeks prior to the survey. Differences in the prevalence and burden of household illness (long-standing illness (1.8 members) and illness reported within the 4 weeks prior to the survey (1.6 members)), though evident, did not vary significantly between socio-economic groups.

3. Other Findings

Selected findings from focus group discussions, facility and key informant interviews and qualitative extracts from the household questionnaire:

- Common diseases cited were: malaria, TB, measles, malnutrition[35], intestinal worms, flu, diarrhoea (the latter 5 being most common for children). Only two groups mentioned AIDS.

[35] It should be noted that these results are taken from the translated transcripts of the FGDs and there may be some error in translation. It may be that malnutrition was used here to describe conditions that result from malnutrition or a vitamin deficiency.

- It was highlighted that it was not always easy to know when someone, particularly a child, was ill. They did not know how to recognise particular symptoms in the early stages.

- Poor people who could not afford to feed their families were more likely to have household members who suffered from illnesses because a child has to eat well to stop becoming sick.

4. Summary

- *1189 (16%) of those surveyed (7,404) had been ill within the specified recall period. Common diseases listed were: Malaria, respiratory problems, and measles, intestinal worms, flu, and diarrhoea, which were common illnesses amongst children.*

- *The pattern of illness prevalence revealed that reporting of illness was lowest among the 6-15 age group (11%) and highest in over 50 age group (25%). Illness reported for the youngest age groups, in particular those under 5 (19%), may be under-reported due to the fact the early signs if illness are difficult to recognise in a child: an issue raised within the focus group discussions.*

- *Proportionally the prevalence of illness reported was significantly higher in women in all age groups (except youngest). This is typically seen in all health care systems and is commonly attributed to the fact that women more often require routine treatment/interventions as defined by questionnaire (that are often not illness but associated with child birth/pregnancy), but also that males may systematically underreport illness.*

- *The prevalence of illness varied significantly across provinces with Gitega reporting higher illness rates (20%) than Mwaro (14%) and Muramvya (15%). However this difference could not be explained by differences in socio-economic status, as the prevalence of illness did not vary significantly by quintile group. Though, it should be recognised that areas where food production is lower may have higher associated level of illness.*

- *Over all households surveyed, forty-nine percent had at least one member who reported having been ill within the 4 weeks prior to the survey date. Significantly more households in Gitega (59%) reported having at least one member who had been ill within the recall period. However, the burden of illness did not vary significantly by province or socio-economic group. On average within the households reporting illness, 1.6 members were ill (i.e. more than one household member was ill during the recall period).*

C. HEALTH SEEKING BEHAVIOUR

a note on the following results: in the household survey respondents who had experienced illness were asked a series of questions that explored the consequential steps undertaken following the onset of illness. The first of these was the decision of the individual member or, in the case of a child, the decision of another household member, regarding whether or not to seek health care or advice from outside of the household.

****From this point the analysis focuses on those respondents who reported having experienced illness episodes within four weeks prior to the survey date *(n=1,189)*. This restriction is used to ensure reasonably accurate data recall.****

a note on definitions used: the following definitions are used in subsequent sections:

- **Treatment outside the household:** this refers to whether the respondent sought health care advice or medical attention from a provider outside of their household as apposed to self-treatment using traditional or allopathic remedies at home. Treatment outside the household could be sought from any of the providers defined below.
- **Private pharmacy/drug store:** this refers to a privately run (i.e. outside of the government sector) independent pharmacy that operates as a legitimate for-profit business. This definition does not include pharmacies attached to public health centres, market traders or herbalists.
- **Public health care centre:** this refers to a health care centre or health post organised and run by central or local government from whom they receive their funding. Staffed by a health worker(s), either a nurse or doctors and nurses. Referred to as the *Centre de Santé*. They usually have their own dispensaries. At the time of the survey the number of public health centres per provinces was recorded as: Gitega 17 (including the prison), Mwaro 14, and Muramvya 10.
- **Private health centre/clinic/hospital:** this refers to an institution where a treatment is provided by a private doctor. At the time of the survey the number of public health centres per provinces was recorded as: Gitega 8, Mwaro 1, and Muramvya 0.
- **Public hospital:** this refers to a centrally run and funded, or semi-autonomous, public facility. These are usually based in the main commune of the province. At the time of the survey the number of public health centres per provinces was recorded as: Gitega 2, Mwaro 2, and Muramvya 2.
- **Missionary health centre or hospital:** generally these are funded by protestant churches do not officially receive public funding. However, they are partially integrated into the public health care system and are responsible to the MoH. At the time of the survey the number of public health centres per provinces was recorded as: Gitega 12 (including 1 hospital), Mwaro 3, and Muramvya 5.
- **Traditional healer:** definitions include a traditional or indigenous practitioner, a herbalist, or a healer.

A list of the public and private health care providers in all 3 provinces is given in Annex 9.

1. Seeking Treatment

note: the rates of those individuals seeking treatments are reported as a percentage of the total number of respondents who reported an episode of illness within the specified recall period: 1,189.

Table 16 summarises the health seeking behaviour of respondents who reported having being ill in the four-week recall period.

Table 16: Health seeking behaviour across gender, age, socio-economic and area groups (n=1,189)

	ILLNESS REPORTED <= 4 WEEKS PRIOR TO SURVEY	CONSULTED OUTSIDE HOME*	ILLNESS REPORTED BUT TREATMENT NOT SOUGHT*
GENDER			
MALE	427 (13%)	345 (81%)	49 (11%)
FEMALE	689 (18%)	556 (81%)	85 (12%)
SIGNIFICANCE	0.001	0.389	
AGE GROUP			
<5	223 (19%)	189 (85%)	17 (8%)
6-15	267 (11%)	204 (76%)	29 (11%)
16-30	259 (16%)	220 (85%)	23 (9%)
31-50	286 (21%)	233 (81%)	35 (12%)
>50	146 (25%)	107 (73%)	33 (23%)
SIGNIFICANCE	0.001	0.001	
QUINTILE GROUP			
POOR	216 (16%)	159 (74%)	37 (17%)
BELOW AVERAGE	231 (17%)	187 (81%)	20 (9%)
AVERAGE	214 (17%)	187 (87%)	14 (7%)
ABOVE AVERAGE	217 (19%)	195 (89%)	11 (5%)
RICH	210 (19%)	187 (89%)	13 (6%)
SIGNIFICANCE	0.233	0.001	
AREA			
GITEGA	446 (20%)	325 (73%)	70 (16%)
MWARO	401 (14%)	353 (88%)	32 (8%)
MURAMVYA	342 (15%)	282 (82%)	36 (11%)
SIGNIFICANCE	0.001	0.001	
ALL (7404)	**1189 (16%)**	**960 (81%)**	**138 (12%)**

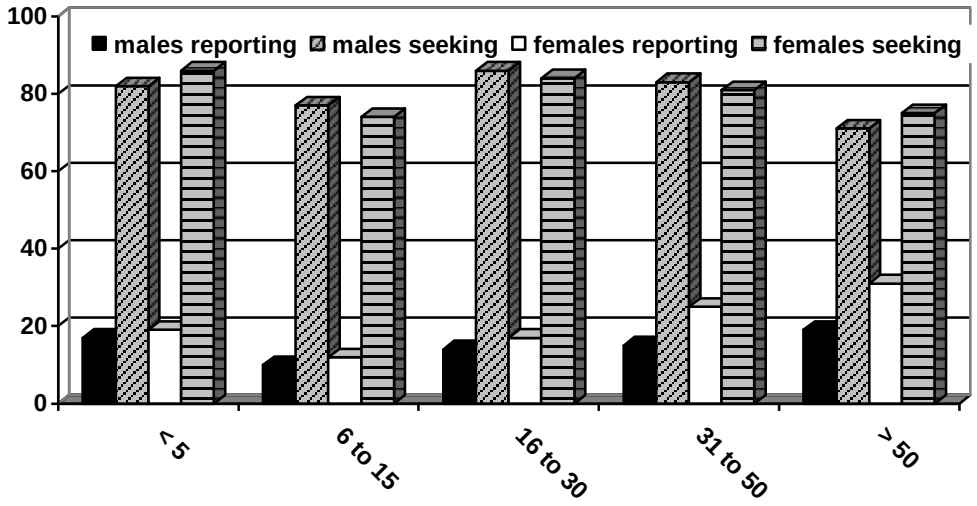
* Overall, 7% of values are missing at these levels.

Overall eighty-one percent (n=960) of those who reported illness **sought health care or advice from outside of the household**. This does not vary significantly across gender groups per se, but statistical differences are evident among the other groups analysed. In all cases, choosing to consult outside of the household and not seeking treatment are significantly associated with the categories in question. The observations differ significantly with 95% confidence.

- **Geographical Area:** As a proportion of the number of ill individuals, respondents in Gitega reported seeking care outside of the household less often (73%) than those in Mwaro (88%) and Muramvya (82%). It is worth noting that Gitega reported a significantly higher prevalence of illness compared to Mwaro and Muramvya, yet significantly fewer respondents in Gitega are sought treatment outside of the household.

- **Age group:** The under 5 age-group and 16-30 age group more often reported seeking care outside of the household (in both cases treatment for 85% of those who were ill was sought outside the home). The 6 to 15 and over 50 age groups sought health care outside of the household less frequently (23% of those over 50 who reported illness did not seek treatment outside the household). Age group results are further disaggregated by gender in Figure 4.

Figure 4: Health care reporting and utilisation by age and gender group (n=6,909)[36]



- **Socio-economic group:** Wealthier groups more often reported seeking care outside of the household, with eighty-nine percent of those reporting illness in each of the two wealthiest quintile groups having consulted outside of the household compared to only seventy-four percent in the poorest group. This is worth noting, since no

[36] N=6,909, the total number of respondents when disaggregated into age and gender groups.

significant difference in the prevalence of illness was found across quintile groups (refer to Table 13).

Further analysis by age and gender showed that there is no significant difference between the proportion of males and females seeking care outside the household in all age groups. This is worth noting because significant differences in the prevalence of illness across genders were observed in all but the youngest age group, with greater proportions of females reporting having been ill in the 4 weeks prior to the survey compared to males (refer to Table 14). This indicates that females may be under-utilising health care in all but the youngest age group, or it may be the result of under-reporting of illness among males. This is illustrated in Figure 4.

Similar results to those ascertained through the individual level analysis were obtained when analysing household responses (Table 17).

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note: seeking treatment at the household level is reported as the number of individuals per households for whom treatment was sought as a percentage of the total number of individuals within a household who reported an episode of illness within the specified recall period: 764.

Table 17: Household illness and treatment seeking behaviour

	HOUSEHOLD ILLNESS REPORTED		PROPORTION OF THOSE ILL SEEKING TREATMENT	
QUINTILE GROUP	**N**	**Mean number of members/household**	**N**	**Proportion of members treated/household**
POOR	140 (55%)	1.54	113 (81%)	0.79
BELOW AVERAGE	152 (59%)	1.52	133 (88%)	0.84
AVERAGE	144 (56%)	1.49	131 (91%)	0.89
ABOVE AVERAGE	129 (50%)	1.68	118 (91%)	0.91
RICH	128 (50%)	1.64	122 (95%)	0.93
AREA	**N**	**Mean number of members/household**	**N**	**Proportion of members treated/household**
GITEGA	294 (59%)	1.52	233 (79%)	0.77
MWARO	256 (19%)	1.57	231 (90%)	0.89
MURAMVYA	214 (40%)	1.60	189 (88%)	0.87
TOTAL	**764 (49%)**	**1.60**	**653 (85%)**	**0.84**

Overall eighty-five percent of households (653) of those who reported having at least one household member with an illness (764) sought health care for their members

outside of the household. Variations in household health seeking behaviour were analysed across geographic and socio-economic groups.

- **Geographical Area:**

The burden of household illness was not found to vary significantly across provinces (refer to point 2 in section B). However, the average number of members treated as a proportion of the number of household members ill, across all households, varied significantly across provinces. Households in Gitega sought health care outside the household for proportionally fewer members (0.77, or, on average out of 3 members ill per household, 2 sought treatment outside the household) as compared to households in Mwaro and Muramvya (where average rates of seeking treatment for ill household members are higher: 0.89 and 0.87).

- **Socio-economic group:**

Similarly, the burden of household illness was not found to vary across socio-economic groups. However, the average proportion of ill members seeking treatment outside the household, across all households, did vary significantly. 'Poor' households sought health care outside of the household for proportionally fewer household members compared to households in wealthier quintile groups.

2. Barriers to seeking treatment

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a note on definitions used: the following definitions are used in sections 2: barriers to seeking treatment, and 3: treatment responses.

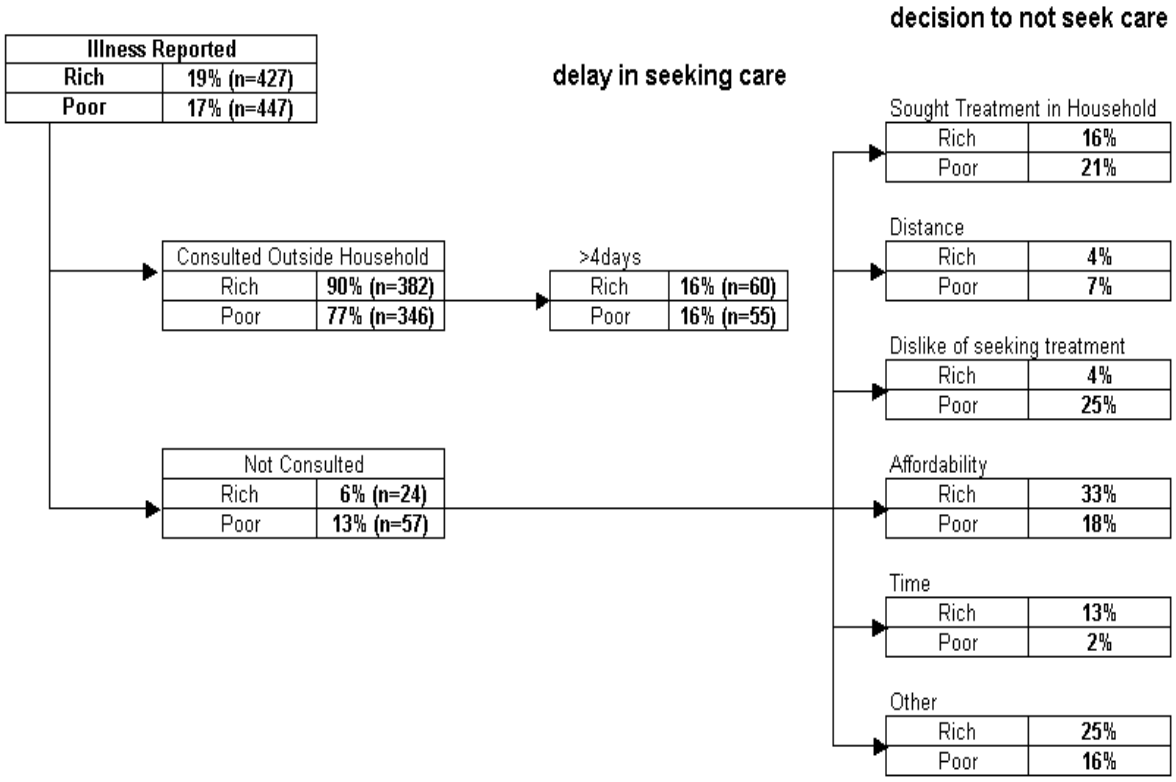
- **Poor:** those individuals who are members of households that are grouped in the two lowest socio-economic quintiles: 'poor' and 'below average' ***(n= 2709)***. Within this group, 17% (n=447) reported experiencing an episode of illness within the recall period and, of these 77% (n=346) sought cares outside the household.

- **Rich:** those individuals who are members of households that are grouped in the two highest socio-economics quintiles: 'above average' and 'rich' ***(n=2253)***. Within this group, 19% (n=427) reported experiencing an episode of illness within the recall period and, of these 90% (n=382) sought cares outside the household.

Overall, **twelve percent (n=138)** of those who reported experiencing an episode of illness within the recall period (n=1,189) **chose not to seek care or advice from outside the household.** Of these, thirty-four percent claimed that their main reason for not doing so was that they 'could not afford to at the time', fifteen percent 'sought treatment from inside the household' and twelve percent 'do not like seeking care'. The decision to seek or not seek care is further disaggregated in Figure 5. This illustrates the differences in the decision strategy between the poorest[37] and wealthiest groups in the survey.

[37] In Figure 5 the 'poor' and the 'rich' are classed according to the definitions above.

Figure 5: Scheme of the decision to seek/not seek care



Rates of non-consultation are statistically significantly higher in the poor socio-economic groups (13% of respondents who reported having been ill chose not to seek care outside of the household) compared to those in the wealthiest groups (6%). Reasons elicited for not seeking care outside the household were:

- Sought treatment within the household
- The distance to the health facility was too far to travel
- Unable to afford treatment at the time
- Unable to afford to take time out of normal activities
- A general dislike of seeking treatment
- Other (including the health facility not well equipped and the lack of trained health staff)

In general, the poor were more likely to treat within the household (21% versus 16%). It is important to note that the type of illness reported may have influenced the decision of whether or not to seek care outside of the household as some illnesses may have been more easily treatable, than others. However, the decision to seek or not seek treatment did not significantly vary with the type of illness reported.

The most often reported access barrier for the poor was a dislike of seeking treatment. The nature of this is not fully understood and it may be correlated with reasons such the embarrassment of not being able to afford treatment, not feeling welcomed by health

staff or other reasons related to the process of obtaining health care. Furthermore it is not clear whether this is a dislike of seeking treatment for itself or a dislike of seeking treatment from particular facilities for reasons that they did not want to disclose. Distance was not rated by many as a barrier in choosing not to seek care. Though differences are evident, the number of responses within each category is too small to calculate any statistical significance.

In further assessing influence of access barriers in the decision not to seek treatment outside of the household, the distance of the household from the three main types of health institution - private pharmacy, health centre (public or private), and public hospital – was used as a crude proxy. In seventy percent of households the nearest pharmacy was over 10km from the household. In contrast, ninety-five percent of households reported that the nearest health centre (public or private) was less than 1km from the household, and around fifty percent of households reported that the nearest hospital was less than 10km. There were no significant differences in the proportions of individuals who sought treatment compared to those who did not seek treatment by household distance from all three institutions.

Finally, an often-overlooked factor that can be used to proxy the presence of barriers to seeking care is the time between the onset of illness and the decision to seek care. Delay in seeking care was reported in the household survey. No statistically significant difference in the delay in seeking care between socio-economic groups, area or gender is evident. However, the delay in seeking treatment did significantly vary across age group, with greater proportions of individuals seeking treatment in older age groups delaying care (23% in the over 50 age group) compared to those seeking care in younger age groups (11% in the under 5 age group).

3. Treatment Responses

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note: treatment responses are illustrated for the **960** individuals who sought health care outside of the household. Again these are split into **'Poor' (n=346)** and **'Rich' (n=382**) groups as defined above.

Of those individuals who reported experiencing an episode of illness within the recall period, eighty-one percent (n=960) chose to seek care from outside the household. The household survey collected information on three consecutive courses of action undertaken for the single episode of illness. The main pathways of care are illustrated in the schematic diagrams shown in **Figure 6: which represents all those who reported an episode of illness within the recall period**, and **Figure 7:** which **represents a simplified pathway** constructed **to highlight any differences between** the choices made by **rich and poor groups**. The main points that can be drawn out from these figures are summarised below.

- Overall, **fifty-three percent** of respondents seeking care outside the household chose to visit a **public health centre** as a first point of contact for treatment outside of the home. Respondents from poor households (54%) more often reported visiting a public health centre than those from rich households (50%), though this difference is not statistically significant.

- The second main pathway was the **missionary health centre or hospital**, which was reported as a first point of contact for **twenty-three percent** of respondents seeking care outside of the household. This choice was reported more often by those from rich households (23%) compared to those from poor households (19%), though, again, the difference is not statistically significant.

Visits to other facilities were reported much less frequently:

- Aside from the numbers visiting public health centres and missionary facilities, significantly higher proportions of individuals from poor households (9%) who sought treatment outside of the household, compared to wealthier households (5%), chose to visit a private pharmacy or drug store. And significantly, proportionally more respondents from poor households (4%) compared to respondents from rich households (2%) visited a traditional healer.

- Similarly, aside form the numbers visiting public health centres and missionary facilities, a significantly higher proportion of respondents from rich households (10%) who sought treatment outside of the households, compared to poor households (5%), visited a private clinic or hospital. And, a significantly higher proportion of respondents from rich households (7%) compared to respondents from poor households (4%) visited a public hospital.

Focusing on the initial choice of facility visited by those seeking treatment outside the household:

- The choice of facility varied significantly across provinces (see Table 18). Proportionally more respondents in Gitega, who sought treatment outside the household, visited a pharmacy (15%) compared with Mwaro and Muramvya. A higher proportion of respondents in Mwaro visited private facilities (14%) compared with those in Gitega and Muramvya. Fewer respondents in Muramvya visited a public health centre (34%), though proportionally more visited missionary facilities (46%) and the public hospital (24%) compared to Gitega and Mwaro.

- Surprisingly, the choice of facility did not vary significantly with the nature of the illness.

- The choice of facility may be dependent on the distance of the facility from the household[38]. The distance of the facility can impact on the decision of whether or not to choose to visit a particular facility. The distance of households from private pharmacies, health care centres (public or private), and public hospitals were cross-tabulated with the choice of facility. Choosing whether or not to visit a pharmacy and a hospital varied significantly with the distance from the household to the nearest pharmacy and distance

[38] This differs from the earlier analysis that examined the impact of the distance of facilities on the decision of whether or not to seek health care from outside of the households. This explored the distance of health facilities as a proxy for analysing access to health care. In this analysis, distance could not be used to explain any differences in choosing whether or not to seek treatment outside the household. Cross-tabulating distance of facility and the choice of visiting that facility can be used to proxy distance as a utilisation barrier.

to nearest hospital. The choice of whether or not to go to the public health centre did not significantly vary with the distance of the household to the facility, though this is not surprising since 95% of respondents reported living within 1km of a health centre.

Table 18: Choice of facility by province (n=960).

FACILITY:	GITEGA (%)	MWARO (%)	MURAMVYA (%)	TOTAL* (%)	SIGNIFICANCE
PHARMACY	48 (15)	6 (2)	3 (1)	**57 (6)**	0.001
PUBLIC HEALTH CENTRE	176 (54)	239 (68)	96 (34)	**511 (53)**	0.001
PRIVATE CLINIC/HOSPITAL	19 (6)	48 (14)	7 (2)	**74 (8)**	0.001
PUBLIC HOSPITAL	4 (1)	19 (5)	24 (9)	**47 (5)**	0.001
MISSIONARY FACILITY	44 (14)	36 (10)	131 (46)	**211 (22)**	0.001
TOTAL*	**325 (100)**	**353 (100)**	**282 (100)**	**960 (100)**	

* including omitted values for facility (i.e. traditional healer and 'other'

Following a first visit, thirty-one percent (n=294) went on to a second visit. A second visit was defined as a self-referral to another facility, an official referral to another facility, or a return visit to the same facility. Proportionally more respondents from wealthier households reported second visits more often (35%) than respondents from poor households (22%). This difference was statistically significant. Assuming that recovery rates from illness do not differ between the wealthier and poor groups, individuals from poor households appear to 'drop-out' from the health care system for other reasons.

For those remaining in the health care system (n=294: poor=75; rich=132), second visits were disaggregated for those respondents who proceeded from a public health centre (n=175; poor=51; rich=69) or missionary health clinic (n=59; poor=11, rich=32) only.

- Of those whose first visit was to a public health care centre, thirty-four percent of respondents proceeded on to a second visit. A significantly higher proportion of respondents from rich households (36%) compared to poor households (27%) reported a second visit

- Of those whose first visit was a missionary health facility, twenty-eight percent proceeded on to a second visit. Again a significantly higher proportion of respondents from rich households (37%) compared to poor households (16%) reported a second visit.

Differences in the pattern of second visits between facility type and between rich and poor groups could not be statistically analysed due to the small sample sizes in the disaggregated groups. However, some points of interest are raised below.

- A large proportion of respondents returned to the same type of facility on their second visit that they visited first (though whether they returned to exactly the same facility was not elicited in the survey). Sixty-three percent returned to a missionary facility and fifty-three percent returned to a public health centre.

- The proportion of respondents who went on to visit a private pharmacy following a visit to a public health facility is four percent compared to those who followed from a missionary facility (zero percent). This suggests that not all the drugs required could be provided by the health centre.

- The large proportion of respondents visiting a public hospital following a visit to a public heath centre (13%) suggests that patients are being referred to another level of care (though it is not clear whether this is self referral or an official referral). There is also some evidence that respondents from public health centres are referred for care at private facilities (9%).

- The proportion of respondents visiting a traditional healer following a visit to either a public health centre or missionary facility was similar (4% and 3% respectively) and may suggest that patients are obtaining traditional remedies that could substitute for the necessity of having to purchase the western drugs prescribed by the health centre.

4. Other Findings

Selected findings from focus group discussions, facility and key informant interviews and qualitative extracts from the household questionnaire:

- Commonly, people reported that when either a child or an adult falls sick they will choose to visit the health centre. If they are really ill or it is an emergency they will go straight to hospital. For minor illnesses you can stay at home and buy medicines locally.

- Adults will often delay seeking care for themselves until they have the money to cover the health care costs. It is preferable not to delay seeking care for children though this cannot be avoided if you have no money or you yourself are sick.

- When seeking care for a child, both parents tend to decide what action to take. Though it is often the mother who recognises when a child is ill.

- No gender differences in seeking care were raised: *"children are considered equal both in the family and at health facilities"*.

- Poverty was repeatedly cited as the most common reason for restricting access to health care. Though the distance of specific facilities (private pharmacies and public hospitals) was also mentioned.

- The key informant interviews revealed that the distance to hospitals may deter poorer individuals from seeking hospital care even if they are officially referred.

- Improved access to private pharmacies was raised because pharmacies stock drugs that are either not available or have run out in public centre dispensaries. Drug shortages at health centres often mean that drugs have to be purchased outside of the centre at private pharmacies (or from market traders (where price and quality cannot be guaranteed)) or substituted with traditional remedies,. *"Sometimes the doctor will need to give you a prescription which you have to take to a private pharmacy or another dispensary*".

- Seeking care through a traditional practitioner or *"witch doctor"* was not viewed to be the first point of call by many but as a last resort when you had no money: *"sometimes you might go to a witch doctor but only because it is cheaper – but you have to do something"*. Further, the key-informant interviews highlighted that many traditional practitioners would allow payment to be delayed or charges were suited to the individual's means. For many it was seen to be a waste of money: *"you do not trust a traditional healer – he is not a proper doctor and you may get more ill when you are treated by him"*.

5. Summary

- *690 (81%) of those reporting having been ill within the recall period, sought health care outside of the household. 183 (12%) chose not to seek care outside of the household.*

- *Ill persons in poor households are less likely to seek care outside of the household (74%). Rates of non-consultation were significantly higher in poor groups (13%) compared to wealthier group (6%). Similarly, poor households sought health care outside of the household for proportionally fewer household members compared to households in wealthier quintile groups. Additionally, respondents from poor household were less likely than those from wealthier household to go onto a second visit and are thereby (since recovery rates not likely to vary) more-likely drop-out from health care system after one visit. Furthermore, significantly fewer respondents in Gitega, as a proportion of those ill, sought care outside the household (73%) compared to other provinces and households in Gitega sought health care outside the household for proportionally fewer members.*

- *For those that chose not to seek care outside of the households, the decision to not seek care did not vary significantly by type of illness. Distance was not rated as a significant barrier in seeking care and the distance from the household to health facilities was not significant in the initial decision to seek care (i.e. barrier in accessing care) . Most respondents (95%) lived within 1km of a health centre (public or private). The most often (34%) cited reason for not seeking care outside of the households was that they 'could not afford to at the time'*

- *For those that sought care, there was no difference in delay in seeking care between wealthy and poor groups. However older age groups were more likely to delay seeking care. Care outside the household was sought for youngest age group (<5) and 16-30 age group more frequently than other ages. This did not vary by gender.*

- *For those people that did seek care outside of the home, the choice of facility varied by quintile group. Most commonly, respondents seeking care outside of the household chose to visit a public health centre (53%) (54% from poor groups, 50% from rich groups) and 23% chose to visit missionary facilities (19% from poor groups, 23% from rich groups). Visits to other facilities were reported much less frequently. Though: respondents from wealthier households were significantly more likely than poor households, to visit a private facility and go to hospital, whereas, poorer households were significantly more likely than rich households, to visit a private pharmacy and a traditional healer.*

- *Surprisingly, the choice of facility did not vary significantly with the nature of the illness. However, the choice of the type of facility visited, varied significantly with the distance of a private pharmacy and public hospital from the household (i.e. barrier to utilising care). The choice of facility also varied significantly across provinces. In the provinces of Gitega (54%) and Mwaro (68%) respondents more often visited public health centres, followed by private pharmacies in Gitega (15%), and private health clinics/hospitals in Mwaro (14%). In Muramvya respondents were less likely to visit public health centre (34%) and more likely, than respondents from Gitega and Mwaro, to visit missionary facilities (46%) and public hospitals (9%).*

- *Expenditures incurred in seeking care outside of the household vary between the type of facility. These are likely to impact on the choice of facility. Refer to the next section for details.*

Figure 6: Pathways of care: all respondents

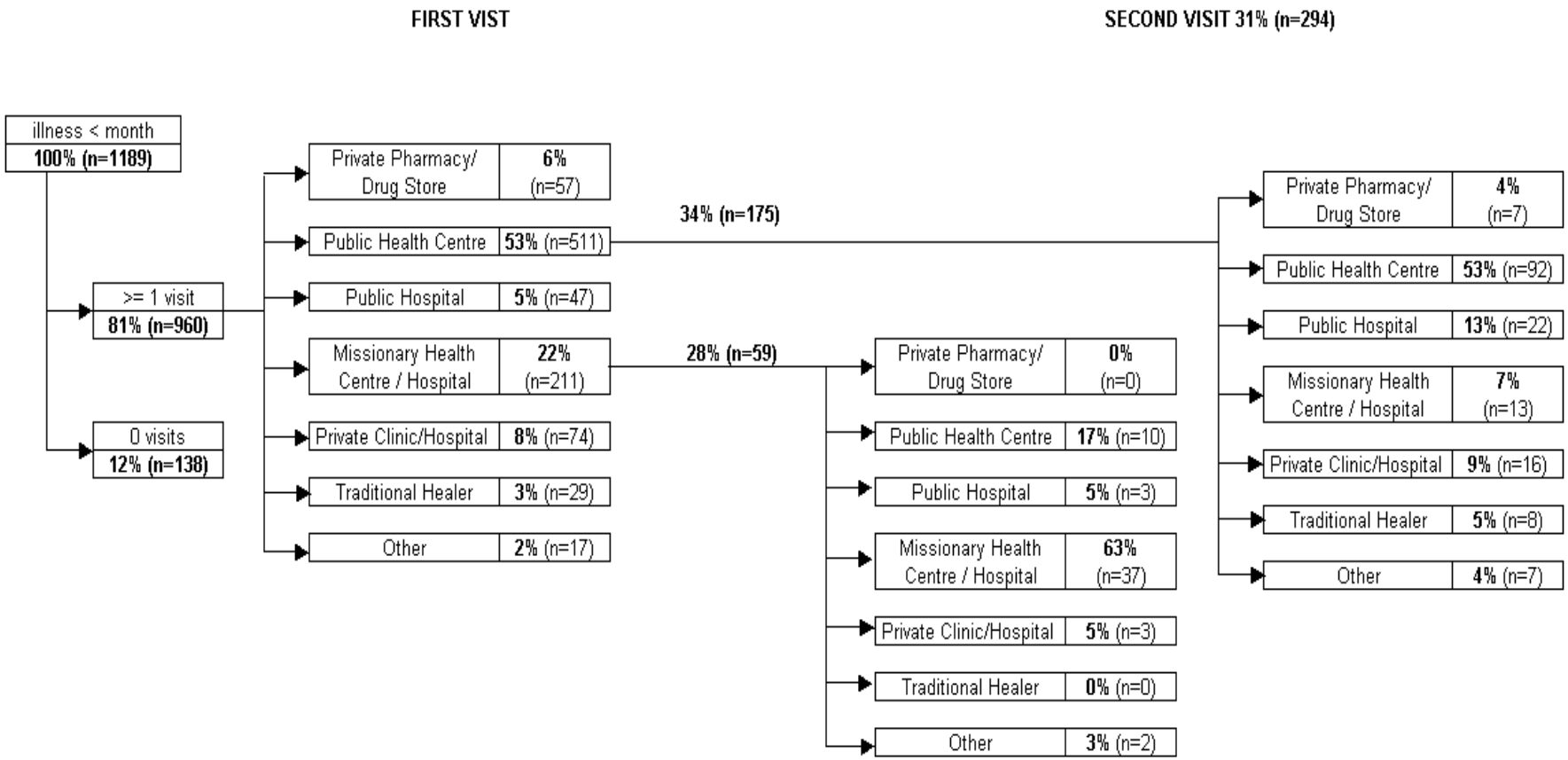
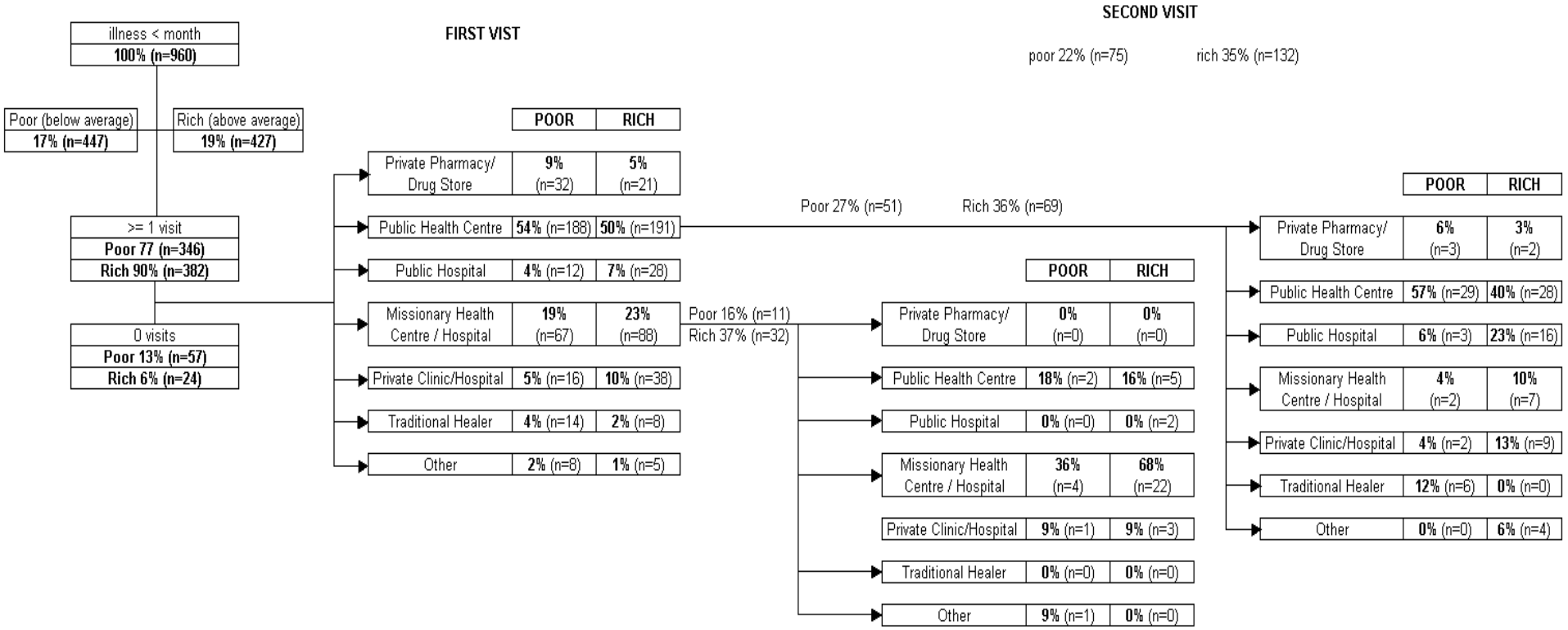


Figure 7: Pathways of care: poor vs. wealthy groups



D. COST OF ILLNESS

a note on the following results: For those that sought health care ***(n=960)***, the monetary and time costs relating to the full episode of illness were collected in the household survey. For the purposes of this analysis, in order to make meaningful comparisons between provinces, the expenditures incurred for the first visit only are explored. The expenditures only reflect the amount that the respondent spent, and cannot be assumed to accurately reflect the price that they faced. The facility interviews attempted to elicit data on charges and prices but the response to these questions was very poor (3).

a note on definitions used: the following definitions are used in subsequent sections:

- **Total health care expenditure:** the total amount spent and amount owed for the health care visit[39]:
- **Expenditure on drugs:** the approximate amount of the total spent on drugs.
- **Expenditure on tests:** the approximate amount of the total spent on tests.
- **Expenditure on food:** the approximate amount of the total spent on food.
- **Expenditure on staff:** the approximate amount of the total spent on payments to health workers, including consultation fees.
- **Money owed:** the approximate amount that is outstanding following the health care visit.

All costs are reported in Burundi Francs (BIF). According to the rate on 01 June 2002 (time of the survey), currency conversion 1USD = 843.670 BIF. .

1. Direct costs:

Data on the direct costs incurred by seeking health care were collected for the 960 individuals who reported having been ill within the recall period and seeking treatment or advice from outside of the household. Complete data was available for 782 respondents, 178 (19%) either found the question too difficult or refused to answer.

Expenditures on health care were greater than zero for all, i.e. all respondents spent money on their health care visit. Similarly, spending within each cost category was also greater than zero. In other words, no respondent faced zero price and none of the respondents that reported having been ill and seeking treatment were exempt from health care payments.

[39] Respondents may have found it difficult to break down the health care expenditures into these categories because they are often not aware of how the total amount that they are charged is divided. Efforts to overcome this were made in the wording of the household questionnaire and interviewing. Total health care spending and any money owed to the facility were easier to collect.

Overall, the average total health expenditure for an average health care visit was estimated to be BIF 2,477.63. This is approximately six percent of the average annual per-capita consumption value (BIF 38,013 – Table 11), or just under an average individual's monthly consumption. The majority of this is spent on drugs (49%) and food (26%), though a large proportion of the total expenditure is still outstanding money owed to the health facility (15%).

Table 19 shows the average (mean) health care expenditures incurred by individuals seeking treatment across provinces.

Table 19: Average health care costs by category and province (n=782).

COST CATEGORY:	AVERAGE (%)	GITEGA (%)	MWARO (%)	MURAMVYA (%)
DRUGS	48.59	75.82	50.39	19.56
TESTS	7.45	3.51	6.50	12.34
FOOD	26.0	4.46	22.67	50.84
STAFF	3.0	5.07	2.38	1.56
MONEY OWED	14.9	11.14	18.05	15.70
TOTAL EXPENDITURE	**BIF 2,477.63**	**BIF 2,312.64**	**BIF 3,557.23**	**BIF 1,563.03**[40]

Total expenditure did not vary significantly between provinces. However, the proportions spent by cost category did. Interesting points to note are:

- The proportion of the total expenditure spent on drugs differed significantly between Gitega (76%), Mwaro (50%), and Muramvya (20%), with respondents in the latter province spending proportionally less on drugs. This is accompanied by greater proportional spending on tests (12%) and food (51%) compared to Gitega and Mwaro.

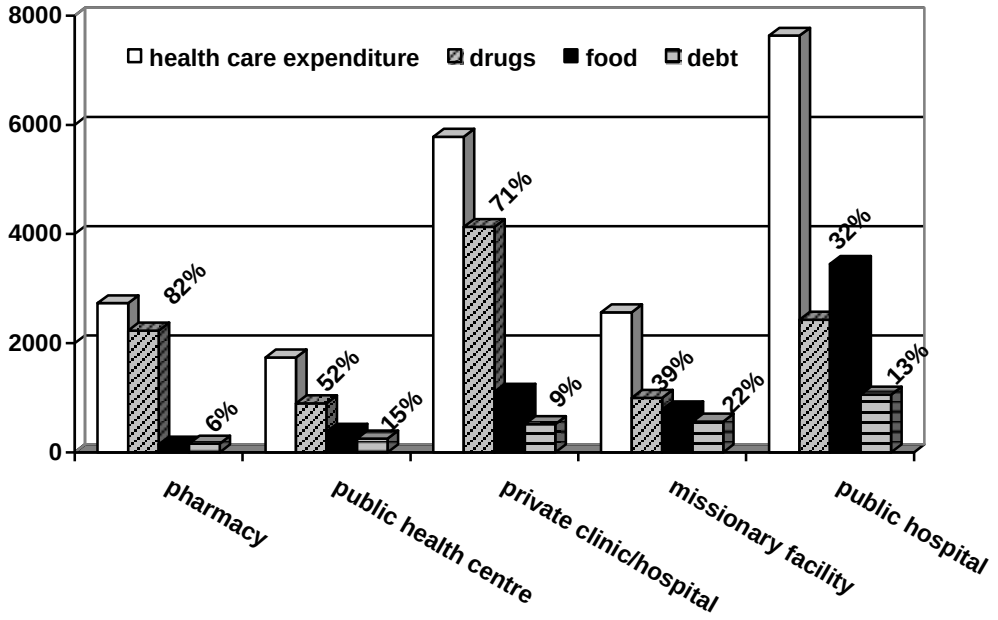
- A greater proportion of total health expenditure in Mwaro is outstanding (18%) as compared to Gitega (11%) and Muramvya (16%).

Total health care expenditure disaggregated by facility is shown in Figure 8. Total health care expenditure is highest in public hospitals (BIF 7,632.98) followed by private clinics/hospital (BIF 5,781.29), private pharmacies (BIF 2,731.63), missionary centres (BIF 2,563.75) and public health centres (BIF 1,736.93), where the reported mean health care costs are lowest. The difference in expenditure varies significantly between facilities.

[40] Given that all care at public health centres was in principle free for all, health expenditures in Muramvya may reflect some illicit charging or they may be associated with the costs of the type of care most commonly sought in Muramvya (seeking care at missionary facilities and public hospitals were most common, and significantly more common than in Gitega and Mwaro provinces – see Table 18). Refer to the following section for the expenditures incurred at these type of facilities.

Expenditure at public hospitals and private clinics/hospitals is significantly higher than that at missionary facilities and public health centres.

Figure 8: Costs of seeking treatment by facility.



Proportionally, the amount spent in each cost category as a percentage of the total health care cost differs according to the type of facility. This is illustrated in Figure 9. Expenditure on drugs makes up the singly largest proportion of the total health care expenditure in all types of facility except public hospitals (where expenditure on food is higher). Proportionally more is spent on drugs in private pharmacies (82%) and private facilities (71%). The proportion of total expenditure spent on drugs is significantly smallest in public hospital (32%), though, since total expenditure is significantly higher in public hospitals, this translates into a figure of BIF 2,443, which is significantly higher than the amount spent on drugs in public health centres and missionary facilities. As a proportion of total expenditure, the proportion outstanding is significantly higher in missionary facilities (22%) followed by public health centres (15%).

Table: 20* Average health expenditure by age group (BIF) (n=)

	<5	6-15	16-30	31-50	>50
TOTAL HEALTH EXPENDITURE	**1,379.72**	**1,579.71**	**2,720.87**	**2,769.12**	**5,973.75**

Total health care expenditure does not vary significantly between gender groups. Moreover, proportionally, variations in expenditure by cost category do not vary statistically, though drugs expenditure is slightly higher for women. Variations in total

expenditure by age group are statistically significant between the over 50 age group, where expenditure is significantly higher (BIF 5,973.75) and the lower age groups (see Table 20). It is important to note that the average health care expenditures do not vary significantly between children and young adults (those under 50).

Total health expenditure differs significantly between quintile groups, with expenditure by respondents in the wealthiest group significantly greater than that in other groups and five times that of the expenditure of respondents in the poorest group (refer to Table 21). However, although respondents in the wealthier quintile groups spend absolutely more on average towards health care, health care expenditures greatly impinge on per-capita consumption of respondents in the poor groups, more so than in wealthier groups. It is worth noting that the health expenditure for the respondents in the poor group is close to a quarter of their average annual per-capita consumption.

Table 21. Average costs by socio-economic group

	EXPENDITURE (% TOTAL)		TOTAL HEALTH CARE EXPENDITURE	
QUINTILE	**DRUGS**	**MONEY OWED**	**BIF**	**% of per-capita consumption**
POOR	64%	14%	979.69	21%
BELOW AVERAGE	62%	12%	1,913.27	15%
AVERAGE	51%	21%	2,850.69	13%
ABOVE AVERAGE	39%	13%	1,732.73	5%
RICH	47%	14%	5,479.61	4%
TOTAL*	**49%**	**14.9**	**2477.63**	**6%**

* including missing values on income

Of interest, the percentage spent on drugs by respondents in the two wealthiest quintile groups is significantly less (39% and 47%) than the proportion of total expenditure spent on drugs in poorer groups. However, actual expenditure on drugs is greatest in the wealthiest quintile group (BIF 2,575.42) and differs significantly from the drugs expenditure of respondents in all other groups. Proportionally, the amount of money outstanding does not differ significantly between quintile groups.

2. Cost and Quality

Differences in health care expenditure may reflect differences in the type of service provided. The most common reason for differentiating health care costs is to discriminate between the 'quality' of care provided. The household survey asked respondents to specify whether certain 'quality indicators'[41] were present in the facility

[41] Quality indicators included statements to establish how the household member was welcomed by staff, the attitudes of staff, the availability of drugs and how well the facility was equipped etc.

they visited. This was used as a proxy for quality. A total of seven statements relating to quality were included in the questionnaire. For the analysis, quality was rated as a percentage of the proportion quality indicators present.

Simple analysis plotting the relationship of cost and quality (see Figure 9*) reveals no clear pattern between them. Furthermore, statistically there is no significant association between the two variables.

Figure 9*: Relationship between expenditure and quality.

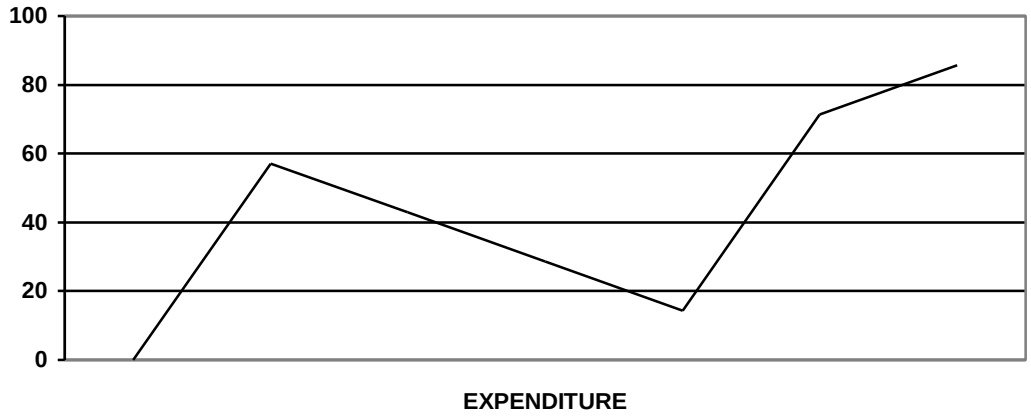
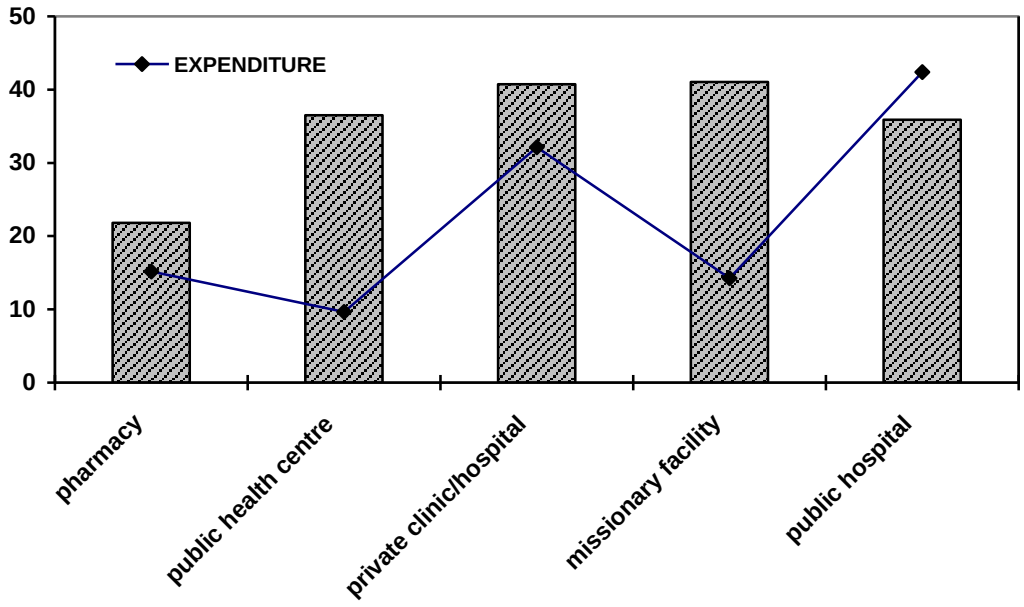


Figure 10*: Quality rating by type of facility.



Quality is more closely related to the type of facility. The quality rating by different facility type is shown in Figure 10*. Quality is rated as significantly high in missionary

facilities (41%) and private facilities (41%). Lower quality ratings are observed for public facilities: health centres (37%) and hospitals (36%). Significantly lower ratings of quality were given for private pharmacies (22%) - though the design of the quality statements were not necessarily appropriate for assessing quality within this type of institution and so this rating may not accurately reflect the levels of quality that are considered to be important when obtaining care through a pharmacy.

Table 22: Quality as rated by socio-economic group

	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	RICH
AVERAGE QUALITY RATING	27.67%	31.78%	40.49%	39.95%	37.43%

Quality ratings by socio-economic groups were also analysed (see Table 22). Ratings were significantly lower for the two poorest socio-economic groups (28% and 32% respectively) as compared to the ratings given by other groups. However, since greater expenditure is not significantly related to higher levels of quality (Figure 9), wealthier groups must either utilise the types of facility where quality is more highly rated, or experience or perceive 'better or improved' quality levels than poorer groups at the same facility.

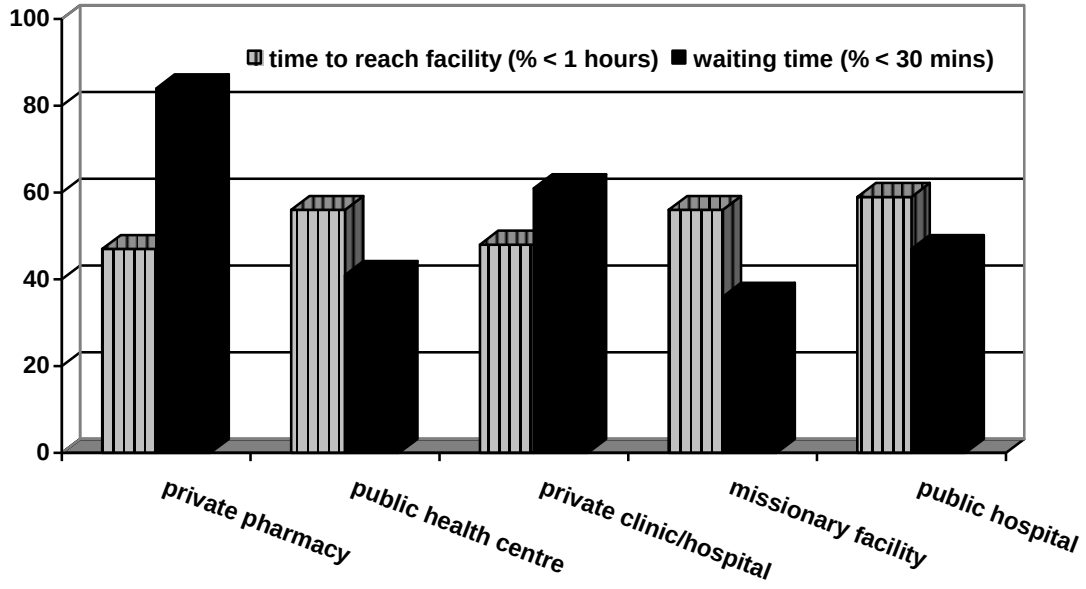
3. Time Costs of Seeking Care

In addition to direct monetary costs, individuals also incur indirect costs such as the time costs in seeking care and receiving treatment, and days lost from normal activity. Indirect time costs also relate to other members of the household who may have lost days from work or accompanied the ill household member. These figures can be converted into monetary costs to reflect more accurately the total costs of care. However, the methodology for this is beyond the scope of this report and median time estimates are used instead.

Overall, more than fifty percent of respondents were able to reach the facility where they sought care in under an hour. It can be seen from Figure 11, that a greater percentage of respondents who sought care at public health centres (56%), public hospitals (59%) and missionary facilities (56%), were able to reach the facility in under an hour. A greater proportion of respondents visiting pharmacies (52%) and private hospitals (51%) reported that the time it took to reach the facility was greater than an hour. The differences in arrival time, though evident, did not vary statistically across facility type.

Waiting times, on the other hand, varied significantly across facility type. Proportionally more respondents who visited private pharmacies (84%) and private clinics/hospitals (61%) had to wait longer than thirty minutes to be seen by an appropriate member of medical staff. Waiting times for public facilities tended to be longer. Proportionally more respondents who visited public health centres (59%), public hospitals (54%) and missionary facilities (64%) had to wait longer than thirty minutes before they were seen.

Figure 11: Arrival and waiting time by facility type.



Similar results were found for variations in arrival and waiting time across quintile groups (refer to Table 23). Proportionally more respondents from wealthier quintile groups reported arriving at the facility in under an hour, though these differences were not statistically significant.

Table 23. Average (median) time incurred whilst seeking care and treatment by socio-economic group (n=960)

	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	RICH
DAYS LOST THROUGH ILLNESS	1 TO 3	4 TO 7	4 TO 7	15 TO 28	15 TO 28
TIME TO ARRIVE AT FACILITY (% < 1 HOUR)	51%	54%	56%	56%	54%
TIME TO BE SEEN AT THE FACILITY (% < 30 MINS)*	39%	37%	50%	47%	43%

* significance = 0.062

However, proportionally fewer respondents from wealthier groups reported having to wait longer than thirty minutes to be seen by an appropriate member of medical staff. Significantly (at 0.10 level) proportionally more respondents in poorer groups (below average) reported having to wait longer than thirty minutes to be seen. This is important to note as waiting time could be indicative of the type of facility poorer groups visit or may reflect discrimination in the treatment of people according to their socio-economic status at facilities. Further differences were found for the days lost from illness, with them being lower for respondents in the poorest quintile compared to those from the wealthier groups. This may reflect the need of poor groups to return to work as soon as possible following any episode of illness.

4. Other Findings

Selected findings from focus group discussions, facility and key informant interviews and qualitative extracts from the household questionnaire:

- Health care costs were generally recognised as being a problem for everyone, especially when more than one member of the household was ill at the same time, or in close succession. However, it was commonly stated that the costs impacted mostly on poor people, and that wealthier people could cope more easily: *"civil servants and merchants do not face problems with health care costs – they can pay medical bills at the end of the month [when they get their salary] and can also [pay incentives to] medical staff to get easy access to care".* The health costs for children were considered to be the same as those for adults but households were also concerned about the escalating health care costs that are incurred when treating elders. The biggest impact on the costs of health care are the costs of drugs and costs were recognised as being highest when seeking care at hospitals.

- Incurring debts at facilities was viewed as both helpful and a hindrance. If an individual could not afford the health costs at public facilities at the time care was received they could pay the money back later. However in some cases people would not be able to seek care at the facility again (for themselves or their family) until these debts had been paid. Further, cases of 'medical jailing' - a phenomenon where people are jailed for failing to pay health care costs - were highlighted in the key informant interviews. In Gitega, it was reported that you must be able to have proof to guarantee payment, or pay *"security fees"* before you can be admitted to hospital.

- Overall, the quality of health services in all provinces was rated as 'good'. The main problems associated with health service provision included shortages in medical supplies and equipment. Respondents in the household survey were willing to pay for improvements in these areas. Generally, people said that they received a warm welcome at facilities and were treated well by health care staff, but stressed that *"the wealthier you are – better treatment you get".* Frequently, interviewees mentioned that you could pay to receive better treatment: *"you do not wait in line according to when you arrived – some poor people have to wait longer"; " they call for people who were behind you because they pay cash. Even when you have your card you have to pay extra money to be received that day – when you are ill you have no choice."*

- Making additional (informal payments) or giving other incentives to health staff was an issue raised by members of the focus groups in all provinces, though there were differences between provinces in the extent to which this was reported: *"one day I gave BIF200 to an orderly but I went home without any medicine"; "I went to hospital for examinations, they refused to give me the results and I knew they wanted money. I hadn't any and just had to go home".*

- A commonly cited problem was that people did not know what they were being charged for or the prices: *"we are not even aware of the price of medicines".*

5. Summary

- *On average, the total health expenditure for a health care visit was BIF 2,478. This is equivalent to around 6% of the average annual per-capita consumption, or just under an individual's average monthly level of consumption. Poor groups spend absolutely less on health care, though in relation to annual levels of consumption, they spend proportionally more (around ¼ of average annual per-capita consumption). The largest component of health care costs is spent on drugs (49%). This is significantly greater in Gitega, followed by Mwaro, and lowest in Muramvya, and is also proportionally greater in expenditures among poorer groups. Following this, the proportions spent on food and outstanding money owed to facilities make-up the next largest components.*

- *Highest expenditure is incurred in public hospitals where proportionally most of these costs are spent on food. As a proportion of total expenditure, the amount outstanding (i.e. debt incurred) is significantly greater in missionary and public health facilities. Low proportions of debt are incurred in private facilities and pharmacies though this is not surprising given they are unlikely to allow credit facilities. However the facility survey suggests that some pharmacy owners may offer credit options if they know the individual. Further, there was no variation in the proportion of debt incurred across all socio-economic groups, suggesting that all groups struggle with costs of health care.*

- *Health care expenditure in young age groups is significantly the same as all other age groups except those in the over 50's age-group (where spending is significantly higher), suggesting that health care costs do not vary between children and adults.*

- *Cost and quality were not significantly associated. Quality tended to rated higher in private facilities (private and missionary) compared to public facilities (health centres and hospitals) where quality was rated lower but expenditure was higher in hospitals, or in the case of the health centre, lower. Moreover, waiting times were longer in public facilities and missionary facilities. Better quality was either experienced or perceived by wealthier groups. Wealthier groups also reported having to wait for less time than poorer groups. This could be indicative of type of facility that respondents from wealthier groups visit, where quality is rated more highly, or this may reflect the fact that different socio-economic groups experience differential treatment at the same facility.*

E. HOUSEHOLD COPING STRATEGIES

The ability of the household to cope and the strategies employed to cover the costs of seeking care and treatment were analysed in the household survey. Households were asked to indicate, from a set list, the strategies they had adopted in order to cover the health care expenses for members of their household. These are summarised in Table 24.

Whilst a significantly (at 0.10 level) greater proportions of households in poor groups (18%) reported to have no coping strategy at all, greater proportions reported relying heavily on selling assets (55% and 61% in the poorest quintile groups) or borrowing money from a friend or relative (22% and 35% in the poorest quintile groups) to cover health care costs. These are risky, irreversible strategies. Additional 'safety-nets' such as reducing household expenditure or using household savings are not common among this poorest group.

Although wealthier groups also most commonly sell assets (58% and 44% in the wealthiest groups) and borrow for friends or relatives (25% and 25% in the wealthiest groups), proportionally more households in wealthier quintile groups tend to have more than one strategy for coping with health care costs. Reducing household expenditure is more common among wealthier groups than poorer groups (though this is not significant) and the use of household savings is significantly proportionally more common in households in the rich groups as compared to the households in poor groups.

Table 24: Household coping strategies across socio-economic groups (n=960*)

STRATEGY*	POOR	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	RICH	SIG
WORKED LONGER HOURS	2%	4%	2%	2%	3%	.453
REDUCED EXPENDITURE	8%	14%	13%	10%	12%	.335
USED HOUSEHOLD SAVINGS	4%	11%	12%	19%	29%	.001
SOLD ASSETS	55%	61%	55%	58%	44%	.018
BORROWED FROM FRIEND	22%	19%	33%	25%	26%	.030
BORROWED FROM LENDER	-	3%	3%	1%	3%	.036
NONE/MISSING	18%	9.6%	10.2%	9.7%	11.8%	.074
TOTAL	**159**	**187**	**187**	**195**	**187**	

* including missing values on socio-economic grouping
** more than one strategy can be adopted by each household

It is also interesting to note that the proportion of households borrowing from a friend or relative significantly increases among wealthier households. This is not to say that these households rely more heavily on borrowing then poor households, but that their ability to borrow is greater due to stronger social networks.

1. Other Findings

Selected findings from focus group discussions, facility and key informant interviews and qualitative extracts from the household questionnaire:

- Health care costs were commonly cited as being hardest to pay during the 'dry season' when households have to pay out many other costs for planting crops and children have to go back to school. During the 'rainy season' it is more difficult to utilise health care because households are busy in the fields and cannot afford the time.
- It was generally agreed that it was the males' responsibility to look for the money to cover health care costs. But: *"big problems are faced when males drink a lot and there is no money for when people in the household fall sick".*
- Where there was no money in the household, alternative strategies for paying health care costs included borrowing money from relatives and friends. Sometimes they would offer money or, sometimes, other types of favours such as transporting the patient, or bringing food for the patient if they were in hospital. Otherwise people would sell their goods or get another job, the money from which would be used to pay off any health care debts. Borrowing money from a formal lender was seen to be a last resort.
- Only one example of a savings scheme was found. In Mwaro a women's co-operative association has been established to help women save for substantial monetary outlays that included covering medical costs.

2. Summary

- *A significantly large proportion (18%) of households in poorer groups have no coping strategy for paying health care costs. Those that do, rely heavily on selling assets (55% and 61% in the poorest quintile groups) or borrowing money from a friend or relative (22% and 35% in the poorest quintile groups) to cover health care costs. These are risky, irreversible strategies and are potentially catastrophic for already poor households who may not be able to recover the costs that they have to pay out or cope when more than household member falls ill, or a household member for whom money was outlaid, dies. Additional 'safety-nets' such as reducing household expenditure or using household savings are not common among this poorest group.*
- *Although wealthier groups also most commonly sell assets (58% and 44% in the wealthiest groups) and borrow for friends or relatives (25% and 25% in the wealthiest groups), proportionally more households in wealthier quintile groups tend to have more than one strategy for coping with health care costs. As well as selling assets and having stronger borrowing power, they are more likely than poor households to use household savings and reduce their household expenditure until bills are paid.*
- *However, very few people appear to save explicitly to cover future health care costs. There was an example of a savings scheme in Mwaro, though this was not specifically aimed at health.*

F. COST PROTECTION AND RISK SHARING STRATEGIES

a note on definitions used: the following definitions are used in this section:

- **Carte d'assurance Maladie (CAM):** every individual (from age zero upward) is expected to pay US$ 0.7 (500FBU) for the cost of a CAM insurance card per year. Community members pay the commune administrator. The CAM card entitles the cardholder to an 80% discount on all services (including drug sales) at the health facility except for the consultation fee (US$0.05), which is compulsory for all at the point of service. It is only accepted at government public facilities and is not accepted at non-government facilities such as missionary and private clinics and hospitals.
- **Carte de la Mutuelle (MFP):** all public sector employees are covered by the MFP card which is paid for by deducting the equivalent of 5% from their monthly salary through the Ministry of Public Function. Again, this card entitles the cardholder to an 80% discount on all services (including drug sales) at the health facility except for the consultation fee (US$0.05), which is compulsory for all at the point of service. The MFP is accepted in missionary facilities (hospitals), public hospitals, and selected pharmacies, not at public or missionary health centres.
- **Point of service payment**: in addition to the consultation fee, all non-card holders (all ages) pay for the total cost of all drugs and other services.
- **Exemptions**: although there are no clear criteria in the circulated government memo on exemption mechanisms, the office of communal administration is charged with the issuance of exemption certificates.
- **Cost-recovery:** at the time this work was undertaken, public health centres in the provinces of Gitega and Mwaro in principle, recovered 20% of the cost was recovered from CAM pre-payment cardholders, and 100% of the cost was recovered from non-cardholders, on all service including drugs. In Muramvya, public health centres, in principle, all CAM cardholders received free-treatment and 100% of service costs were recovered from non-cardholders.
- **Adverse Selection:** phenomenon common to insurance schemes when many high-risk individuals (in the case of health: those most likely to get sick or those with chronic illnesses - those in most need of health care) join up to a voluntary insurance scheme. This means greater claims and higher expenditures, reducing the financial viability of the scheme. If this is the case, premiums will have to be raised, the level of cover reduced, or the 'higher-risks' excluded.
- **Moral Hazard:** used to describe the change in behaviour observed when people are covered by insurance. Insurance coverage may result in individuals becoming more careless, and may result in more claims. In the case of health this tends to manifest itself as overuse of services for minor complaints. Increased claims can result in higher costs and again reduce the financial viability of the scheme.

1. Pre-payment insurance coverage

note: insurance coverage data was elicited in the household survey and covers all those who responded regardless of whether they were ill or sought health care (**n=7,404)**.

A total of 7,111 respondents answered questions on pre-payment schemes. Data on the take up of pre-payment insurance across area and socio-economic group is shown in Table 25.

Table 25: Pre-payment insurance coverage by socio-economic group and area (n=7,404)

	CARTE D'ASSURANCE MALADIE (CAM)	CARTE DE LA MUTUELLE (MFP)	BON DE SOINS	NONE*	TOTAL COVERED
GITEGA	289 (13%)	111 (5%)	3 (0.1%)	1749 (78%)	18.1%
MWARO	718 (25%)	388 (13%)	19 (1%)	1615 (55%)	39%
MURAMVYA	500 (22%)	162 (7%)	4 (2%)	1553 (69%)	31%
POOR	254 (19%)	48 (4%)	-	971 (73%)	23%
BELOW AVERAGE	266 (19%)	70 (5%)	2 (0.1%)	1006 (72%)	24.1%
AVERAGE	239 (19%)	82 (7%)	8 (1%)	889 (71%)	27%
ABOVE AVERAGE	326 (28%)	129(11%)	7 (1%)	655 (56%)	40%
RICH	245 (23%)	253 (23%)	9 (1%)	519 (48%)	47%
TOTAL**	**1507 (20%)**	**661 (9%)**	**26 (0.4%)**	**4917 (66%)**	**29.4%**

* only included data from individuals who stated that they did not posses any of the insurance cards mentioned. This figure does not include missing values on insurance ownership.
** including any missing values on socio-economic status

Overall, out of the total 7,404 households sampled in the survey, sixty-six percent do not posses any form of pre-payment insurance card and only twenty-nine percent are covered by one of the pre-payment schemes. The majority (20%) possess the CAM card whilst a low proportion of respondents (0.4%) possess the "bon de soins"

The proportion of respondents with and without some form of pre-payment card varies significantly across provinces. Insurance coverage is proportionally higher in Mwaro (39%) and Muramvya (31%) compared to Gitega where seventy-eight percent of respondents claim they do not possess any form of pre-payment card. This difference is consistent for the proportion of respondents in possession of CAM cards. The possession of MFP cards also differs significantly across provinces, though both Gitega (5%) and Muramvya (7%) have proportionally fewer respondents possessing MFP cards compared to Mwaro (13%). Differences in the possession of the bon de soins could not be statistically analysed.

Significantly, proportionally more respondents from households in poorer quintile groups were not covered by any pre-payment schemes (73% in the poorest quintile group). Respondents from wealthier socio-economic groups more often reported possessing pre-payment insurance than respondents from households in poor groups. This is true for all types of insurance, though there is a greater income gradient in the proportion of respondents possessing MFP cards compared to CAM cards (i.e. the proportion of respondents possessing MFP cards increases at a greater rate across quintile groups than the proportion of respondents possessing CAM cards).

Further analysis on the possession of pre-payment insurance is disaggregated into age and gender groups (Table 26). For the purposes of this analysis, membership of the bon de soins scheme is disregarded.

Table 26: Pre-payment insurance coverage by age and gender groups (n=7404)

	CAM	MFP	TOTAL INSURED**	NONE	TOTAL*
MALE	650 (21%)	294 (9%)	944 (30%)	2086 (66%)	3166
FEMALE	781 (21%)	336 (8%)	1117 (29%)	2544 (67%)	3800
< 5	254 (21%)	121 (10%)	375 (31%)	719 (60%)	1205
6-15	509 (20%)	209 (8%)	718 (28%)	1649 (65%)	2521
16-30	319 (19%)	129 (8%)	448 (27%)	1190 (71%)	1669
31-50	289 (21%)	123 (9%)	412 (30%)	942 (68%)	1368
>50	129 (22%)	70 (12%)	199 (34%)	372 (64%)	579
TOTAL*	**1507 (20%)**	**661 (9%)**	**2168 (29%)**	**4917 (66%)**	**7404**

* including any missing values on gender and age group
** excluding bon de soins scheme

There is no significant difference across gender groups in the proportion of respondents insured through a pre-payment scheme compared to those not covered. Furthermore, there is no difference in the proportion of males compared to females insured through the CAM and MFP pre-payment schemes.

Significant differences across age groups are observed for the proportion of those groups who are insured compared with those who have no insurance coverage. Proportionally more respondents in the over 50-age group reported being insured through one of the two schemes (34%) and fewer were not covered at all (64%) compared to other groups. Similarly, children in the under 5-age group were covered by one of the schemes (31%) and proportionally fewer in this age group were not covered at all (60%) compared to other age groups. Respondents in the 16-30 age group report significantly proportionally the least number are covered by either scheme (27%) and the greatest number that are not members of any pre-payment insurance (71%). There are no significant differences between the proportions of respondents covered by the CAM scheme and the MFP scheme across age groups. Moreover, there are no statistically significant differences across gender groups within each age group for the analyses presented above.

For the 4,917 respondents not possessing any form of pre-payment card, reasons for not doing so are summarised in Table 27.

Table 27: Reasons for non-possession (not possessing any pre-payment card) (n=4,917)

	<18 OR STUDENT	COULD NOT AFFORD	NOT USEFUL	NOT AVAILABLE	NOT YET BOUGHT	TOTAL*
POOR	376 (39%)	249 (26%)	139 (14%)	14 (1%)	109 (11%)	**971**
BELOW AVERAGE	410 (41%)	185 (18%)	161 (16%)	44 (4%)	108 (11%)	**1006**
AVERAGE	372 (42%)	157 (18%)	135 (15%)	44 (5%)	113 (13%)	**889**
ABOVE AVERAGE	232 (35%)	97 (15%)	96 (15%)	15 (2%)	134 (20%)	**655**
RICH	160 (31%)	64 (12%)	93 (18%)	41 (8%)	98 (19%)	**519**
GITEGA	472 (27%)	498 (28%)	328 (19%)	58 (3%)	190 (11%)	**1749**
MWARO	628 (39%)	362 (22%)	173 (11%)	86 (5%)	240 (15%)	**1615**
MURAMVYA	770 (50%)	146 (9%)	234 (15%)	26 (2%)	226 (15%)	**1553**
TOTAL*	**1870 (38%)**	**1006 (20%)**	**735 (15%)**	**170 (3%)**	**656 (13%)**	**4917**

*including 'other' (exempt anyway, never sick, didn't know it existed) and missing values

Of importance to note is the fact that the majority of respondents across all socio-economic groups and provinces (38%) report that the primary reason for not possessing any pre-payment card is that they are either under the age of 18 or a student. This is particularly interesting given that none of the schemes exempt students or minors.

Significantly, proportionally more respondents from poorer households (26%) report not being able to afford the pre-payment card. This also varies significantly across provinces, with proportionally more respondents from Gitega (28%) and Mwaro (22%), as compared to respondents from Muramvya (only 9%), citing their inability to afford a card as a reason for not possessing pre-payment insurance. Proportionally more respondents from wealthier households compared to respondents from poorer households reported that they did not find the cards useful, they were not available when they attempted to purchase one, or they had not yet purchased a card but did intend to do so. These differences were significant. Similar significant differences were observed across provinces. Proportionally more respondents from Gitega (19%) reported that they did not find owning a card useful and proportionally more respondents from Mwaro (5%) indicated that the card was not available when they tried to purchase it.

2. Exemptions

note: exemption status data was elicited in the household survey and covers all those who responded regardless of whether they were ill or sought health care (**n=7,404)**.

Some individuals are exempt from needing to purchase a pre-payment card and from paying the full costs of health care, primarily for reasons of poverty. Questions on exemption status were elicited in the household survey. This data is presented in Table 28.

Table 28: Exemption status data (n=7,404)

	AWARE OF EXEMPTION	QUALIFY FOR EXEMPTION	POSSESSION OF CERTIFICATE	BENEFIT FROM EXEMPTION	TOTAL
POOR	50 (4%)	28 out of 736 (4%)	20 out of 28 (71%)	10 out of 20 (50%)	**1322**
BELOW AVERAGE	127 (9%)				**1387**
AVERAGE	127 (10%)				**1249**
ABOVE AVERAGE	169 (14%)				**1169**
RICH	209 (19%)				**1084**
GITEGA	94 (4%)				**2255**
MWARO	408 (14%)				**2886**
MURAMVYA	234 (10%)				**2263**
TOTAL	**736 (10%)**				**7404**

Initial analysis was disaggregated according to socio-economic group and province. However, the numbers are too small in subsequent analyses to allow any meaningful comparisons across these groups and the results are combined.

Overall, only 736 (10%) of the sample population were aware of the existence of an exemption scheme, 4,106 (55%) explicitly stated that they were not aware of such a scheme, and 2,562 (35%) respondents refused to respond or weren't sure.

Awareness of any form of exemption scheme whereby people are exempt from paying the full costs of health care varied significantly across both quintile groups and provinces. Proportionally more respondents from wealthier socio-economic groups reported being aware of the existence of an exemption scheme ('rich' = 19%, 'above average' = 14%) compared to respondents in poorer groups ('poor' = 4%, 'below average' = 9%). Similarly, respondents from Gitega (4%) were proportionally less likely to be aware of such a scheme compared to respondents from Mwaro (14%) and Muramvya (10%). Of the total (736) respondents who were aware of the existence of an exemption scheme,

four percent (28) actually qualified for exemption status (self reported). Most of these respondents (50%) claimed that they possess a poverty certificate to prove their exemption status, yet half reported that they did not benefit from exemption at every health care visit and sometimes had to contribute fully to health care costs (this may have depended on the type of health care facility they were visiting).

3. Pre-payment scheme features

Important features of the pre-payment schemes to note are:

- *Social features:* whether the pre-payment scheme is successful as a protection mechanism to protect against the high costs of health care, i.e. possessing a pre-payment insurance card is beneficial in terms of reducing the costs of care. In practice a patient with an insurance card should only pay a small percentage (20%) of the costs of care compared to those who have no insurance.

- *Financial features:* whether the pre-payment scheme operates successfully as an insurance scheme to a pool of health care funds that is financially viable and sustainable i.e. the effects of moral hazard and adverse selection (phenomenon observed in the insurance domain) are minimal and do not alter the risk pool over which the health funds are raised.

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note: in analysing the social and financial features of the pre-payment schemes, the data on card ownership was analysed only for:

- *social features*: those who completed data on payment card ownership, (CAM, MFP, or none) *and* had sought health care outside of the household **(n=782)**.
- *financial features*: those who completed data on payment card ownership, (CAM, MFP, or none) *and* had experienced illness or not **(n=7,085)** and those who sought care outside of the households or not **(n=1,066)**.

- ***Social Features***

In analysing the social features of the pre-payment cards, total average expenditure and the proportions spent in each cost category were disaggregated by the type of pre-payment card and by province (Table 29). As previously highlighted (refer to cost of illness, section D), the expenditure figures only represent the amount spent by each group and do not necessarily reflect the price that they faced. The analysis concentrates on difference in the proportions spent on drugs as this has the greatest impact on total health care expenditure (refer to section D).

Overall, expenditure on health care is higher among groups possessing an MFP card. Total expenditure differs significantly between those possessing MFP cards and CAM cards, but there is no significant difference in the total average expenditure between those respondents who have CAM cards and those with no form of pre-payment insurance. Further, there are no significant differences in the proportion of total

expenditure spent on drugs, tests, and food, nor money owed, between all groups. Only the proportion of total expenditure spent on staff consultations differs significantly. This is higher among groups who posses some form of pre-payment card.

Table 29: Variations in average expenditure by pre-payment card type (BIF) (n=782)

	CAM	MFP	NONE
ALL PROVINCES			
TOTAL	**2248.72**	**6465.49**	**2277.16**
DRUGS	47% (1056.89)	52% (3390.50)	53% (1208.03)
TESTS	9% (202.38)	6% (368.53)	6% (147.79)
FOOD	25% (562.18)	26% (1662.92)	22% (508.03)
STAFF	5% (112.44)	4% (265.08)	3% (60.11)
MONEY OWED	14% (314.82)	12% (784.91)	16% (353.42)
GITEGA			
TOTAL	**1405.14**	**3481.21**	**2405.92**
DRUGS	71.43 (1003.69)	69.64 (2424.31)	76.32 (1836.2)
MWARO			
TOTAL	**2786.34**	**10,356.00**	**3004.25**
DRUGS	42.39 (1181.13)	54.16 (5608.81)	53.90 (1619.29)
MURAMVYA			
TOTAL	**1793.75**	**3921.16**	**1201.31**
DRUGS	30.66 (549.96)	32.79 (1285.75)	15.27 (183.44)

Analysis by province shows that:

- *Gitega:* even though differences in the average total expenditure are evident across different groups possessing pre-payment cards, these differences are not statistically significant. This is also true for the proportion of total expenditure spent on drugs.

- *Mwaro:* differences in average total expenditure are statistically significant between those possessing an MFP card and those with CAM cards or no card. In other words, total average expenditure is reported to be greater for those groups who posses MFP cards and there is no difference in the total average expenditure between CAM cardholders and the expenditure reported by those possessing no form of pre-payment card. However, the proportion of total expenditure spent on drugs differs significantly (with 90% confidence) between

CAM cardholders, who contributed significantly less (42%), and MFP cardholders and those with no card (54%).

- *Muramvya*: similar results to those found for Mwaro are evident in Muramvya. Differences in average total expenditure are statistically significant between those possessing an MFP card and those with CAM cards or no card. There is no difference in the total average expenditure between CAM cardholders and those possessing no form of pre-payment card. Proportionally the amount spent on drugs is reported to be significantly (with 90% confidence) greater for MFP (33%) and CAM (31%) cardholders than those with no card (15%).

- ***Financial Features***

To analyse the effects of adverse selection, reported illness rates (refer to section B) were cross-tabulated with the type of pre-payment card possessed. Evidence of adverse selection is evident if illness rates are higher among those groups who purchased some form of pre-payment card, i.e. those with higher risks of illness are more likely to opt to buy these cards. Higher rates of health care seeking among individuals covered by pre-payment insurance schemes are taken as a potential indicator of the presence of moral hazard. Those who face lower health care costs may utilise the health system at a greater rate than those who have to cover the full costs of their health care. Results are presented in Table 30.

Proportionally, there are significant differences in the illness rates across those groups who are covered by some form of pre-payment scheme (CAM or MFP) and those who reported not possessing any form of pre-payment insurance card. Illness rates are significantly higher among this latter group (18%) as compared to the rate reported among pre-payment cardholders (13%). Further, there is no significant difference between the illness rates reported across CAM cardholders (14%) and MFP cardholders (12%). Adverse selection among individuals therefore does not appear to be a problem.

The rate of seeking care outside the household varies significantly across the groups. Rates of seeking care were reported to be significantly higher among those groups who are covered by some form of pre-payment scheme (87%) compared to those not possessing any pre-payment card (79%). There are, however, no differences between the proportion of respondents seeking care with CAM (85%) and MFP (93%) cards. Assuming that illness severity is equal across the groups, there is evidence that respondents in possession of a pre-payment card are more likely to utilise health services than those who do not own a card. This suggests that moral hazard may be a problem, though it is more realistic to conclude that since health care seeking rates are still comparatively low[42] compared to other low income countries[43], the effect of insurance on utilisation is a 'price' effect, i.e. more people are utilising the service because they can afford to.

[42] For those insured, the number health care of visits per person per year can be calculated as: (percentage ill within recall: 4 weeks/1 month)*(percentage seeking health care)*(12: number of months in year) = 0.13*0.87*12 = 1.4 visits per person per year.

[43] This is similar to the rates reported for other sub-Saharan African countries = 1, but comparatively to other low-income countries = 3, and far lower than the average for developed countries = 4-6 (WHO, 2001).

Table 30: Effects of adverse selection and moral hazard by pre-payment card type.

	TYPE OF PRE-PAYMENT SCHEME			
	CAM	**MFP**	**NONE**	**BOTH (i.e. insured)**
*Illness rates (7404)**				
ILL (WITHIN RECALL)	**213 (14%)**	**80 (12%)**	**861 (18%)**	**293 (13%)**
NO ILLNESS (IN RECALL)	1294	581	4056	1875
TOTAL	1507	661	4917	2168
SIGNIFICANCE	0.113		0.001	
*Health seeking behaviour (1189)***				
SOUGHT CARE	**181 (85%)**	**74 (93%)**	**676 (79%)**	**255 (87%)**
DID NOT SEEK CARE	13	2	120	15
TOTAL***	213	80	861	293
SIGNIFICANCE	0.154		0.001	

* includes missing or omitted values on card ownership (n=319)
** includes missing or omitted values on card ownership (n=35)
*** includes missing values on seeking/not seeking care (n=88)

4. Other Findings

Selected findings from focus group discussions, facility and key informant interviews and qualitative extracts from the household questionnaire:

- The most common cards purchased were reported to be the CAM card and MFP card. MFP cards are bought by *"wealthy people mostly"*. But poor people still cannot afford the price of the CAM and *"when anybody becomes sick they have more problems because the costs are more"*.

- The issue of who needed to buy cards was confused. Some people thought that everybody had to have their own CAM card. Others suggested that you could have your children added to your card – though it was not clear whether you had to pay for this. However it was agreed that families that held an MFP card had everybody covered on it. Reasons for not purchasing cards included: *"being in poverty"; "sometimes the cards are sold out"; "not all people are aware of the card or its benefits"; "postponing buying a card until it is needed* (i.e. someone is ill)*"*.

- It was recognised that by owning a card you were entitled to a discount in health care costs, though they did not always know what the reduction should be (quotes included: ¼, 20%, or ½). However, the key informant interviews suggested that sometimes people possessing CAM are charged more then they should be as many are not aware of what they should be paying

- In many cases, people agreed that the cards had helped them to get access to health care services because of the reduced costs.

- However, there were also problems associated with the cards. It was reported that sometimes the cards were held at facilities until a debt at that facility had been paid off. And, additionally, focus group members in Mwaro were disillusioned with the CAM card: *"we bought the cards at first because they were helpful with paying health care costs and staff received and welcomed you rapidly, it had benefits at first because you could cover your whole family … now the card to me is useless there is no difference in price", "to me the card is useless if you have no money … it's better to use full cash than buy a card", "we have been told that the card is being suppressed".*

- In order to receive the discount, CAM cards could only be used at public 'state' facilities (public health centres and public hospitals) and MFP cards could only be used at missionary facilities, hospitals and public hospitals.

- In order to receive exemption status, you had to be considered (by the commune administration) to be very poor. Other people who were considered to be entitled to exemption included those who have mental illness, refugees, the widowed, orphaned, or prisoners. Ignorance (people not being aware of what they are entitled to) was most commonly reported in facility and key informant interviews as a reason for people who were entitled to exemption status not receiving it.

- However, making informal payments or providing incentives to obtain exemption status was frequently reported but this depended on the administration. Common statements included: *"some people get exemptions because they are close to the administrator – there are many such people living in my area"; "sometimes people ask for a bribe to give the sick person the document they need, in some cases if he doesn't give a bribe, he doesn't get the document"; "I can give you an example of at least 5 people that have obtained exemption dishonestly. The one who really needs it is the one who hasn't got it because he didn't have anything to give …".*

- Furthermore, some people who are entitled to exemption status cannot get it because they are unable to get to see the administrator: they cannot physically get there, or he will not receive them; or they have nobody to advocate their case for them. Others are not familiar with the process: *"sometimes the administrator doesn't receive you when you go to see him. He stays there as if he is not there, you go even three times, it's a shame"; "as a refugee I don't know where to go, I have been to try to see right people but they refuse to see me – they say they want a bottle* (a beer) *to write the paper".*

- Respondents in the household survey reported that they believed the government should provide free health care to those who cannot pay and others with identifiable needs. They also suggested that when paying for health care, they would prefer to pay a small amount each month and pay a small percentage when they utilise health services.

5. Summary

- *Only 29.4% of respondents possessed some form of pre-payment insurance card. The majority possessed the CAM card (20%), followed by the MFP card (9%) and few respondents reported possessing the Boin de soins (0.4%). However this is not surprising given the target groups of the different cards.*

- *Insurance coverage is proportionally higher in Mwaro (39%) and Muramvya (31%) compared to Gitega where seventy-eight percent of respondents claim they do not possess any form of pre-payment card. This difference is consistent for the proportion of respondents in possession of CAM cards. The possession of MFP cards also differs significantly across provinces, though both Gitega (5%) and*

Muramvya (7%) have proportionally fewer respondents possessing MFP cards compared to Mwaro (13%). Furthermore, respondents from wealthier socio-economic groups more often reported possessing pre-payment insurance than respondents from households in poor groups. This is true for all types of insurance, though there is a greater income gradient in the proportion of respondents possessing MFP cards compared to CAM cards (i.e. the proportion of respondents possessing MFP cards increases at a greater rate across quintile groups than the proportion of respondents possessing CAM cards). Coverage also differed among age groups with the very young (<5) and very old (>50) being more likely, than other age groups, to be covered by either of the two schemes.

- *The major reason for not possessing any pre-payment card was that the respondent classed themselves as either under the age of 18 or a student. This is particularly interesting given that none of the schemes exempt students or minors Significantly, proportionally more respondents from poorer households (26%) reported not being able to afford the pre-payment card. This also varies significantly across provinces, with proportionally more respondents from Gitega (28%) and Mwaro (22%), citing their inability to afford a card as a reason for not possessing pre-payment insurance. Proportionally more respondents from wealthier households compared to respondents from poorer households reported that they did not find the cards useful, they were not available when they attempted to purchase one, or they had not yet purchased a card but did intend to do so.*

- *Only 10% of the sample was aware of the existence of an exemption scheme. Proportionally more of these were in the wealthier groups (only 4% in the poorest group were aware of the scheme). Furthermore, of those aware of the scheme, only 4% actually qualified for exemption and half possessed exemption papers. Most of these respondents were from wealthier groups (though the numbers are too small to analyse statistically).*

- *Social features of pre-payment.*

For those paying for health care, expenditures were highest among those groups using MFP cards. This is true over all provinces. There were no significant differences between expenditures reported by CAM cardholders and respondents who did not hold any pre-payment card. This may indicate that those with CAM cards are not getting full discount entitled too or it may be that they are receiving more expensive treatments. The proportions of total expenditure spent on drugs are lower in Muramvya than Gitega and Mwaro. However expenditures for all individuals are not zero as may have been expected (since they are subsidised 100% in Muramvya). This indicates either, individuals are still being charged for drugs or are purchasing drugs from elsewhere where they cannot use the card.

- *Financial features of pre-payment.*

Proportionally, there are significant differences in the illness rates across those groups who are covered by some form of pre-payment scheme (CAM or MFP) and those who reported not possessing any form of pre-payment insurance card. Illness rates are significantly higher among this latter group (18%) as compared to the rate reported among pre-payment cardholders (13%). Further, there is no significant difference between the illness rates reported across CAM cardholders (14%) and MFP cardholders (12%). Adverse selection among individuals therefore does not appear to be a problem.

Rates of seeking care were reported to be significantly higher among those groups who are covered by some form of pre-payment scheme (87%) compared to those not possessing any pre-payment card (79%). There are, however, no differences between the proportion of respondents seeking care with CAM (85%) and MFP (93%) cards. Assuming that illness severity is equal across the groups, there is evidence that respondents in possession of a pre-payment card are more likely to utilise health services than those who do not own a card. This suggests that moral hazard may be a problem, though it is more realistic to conclude that since health care seeking rates are still comparatively low compared to other low income countries, the effect of insurance on utilisation is a 'price' effect, i.e. more people are utilising the service because they can afford to..

PART FOUR: DISCUSSION AND CONCLUSIONS

This part of the report discusses the results with reference to the research objectives and concludes by highlighting the next steps and possible future strategies, drawing on examples from the region.

A. RESEARCH OBJECTIVES REVISITED

- ***How was illness distributed over households – was it concentrated in a small proportion of households or spread quite evenly?***

The prevalence of illness was not significantly associated with quintile group, i.e. illness did not vary significantly across quintile groups. Prevalence did, however, vary across the other groups analysed. The pattern of illness prevalence revealed that reporting of illness was lowest among the 6-15 age group (11%) and highest in over 50 age group (25%). Illness reported for the youngest age groups, in particular those under 5 (19%), may be under-reported due to the fact the early signs of illness are difficult to recognise in a child: an issue raised within the focus group discussions. Proportionally the prevalence of illness reported was significantly higher in women in all age groups (except youngest). This is typically seen in all health care systems and is commonly attributed to the fact that women more often require routine treatment/interventions as defined by questionnaire (that are often not illness but associated with child birth/pregnancy), but also that males may systematically underreport illness.

Over all households surveyed, forty-nine percent had at least one member who reported having been ill within the 4 weeks prior to the survey date. On average within the households reporting illness, 1.6 members were ill (i.e. more than one household member was ill during the recall period).

- ***How did treatment response vary by type of household or individual?***

690 (81%) of those reporting having been ill within the recall period, sought health care outside of the household. 183 (12%) chose not to seek care outside of the household. Most commonly, respondents seeking care outside of the household chose to visit a public health centre (53%) followed by missionary facilities (23%). Visits to other facilities were reported much less frequently.

- ***How did treatment response vary by social / age / gender groupings?***

Ill persons in poor households are less likely to seek care outside of the household (74%). Rates of non-consultation were significantly higher in poor groups (13%) compared to wealthier group (6%). Similarly, poor households sought health care outside of the household for proportionally fewer household members compared to households in wealthier quintile groups. Additionally, respondents from poor household were less likely than those from wealthier household to go onto a second visit and are thereby

(since recovery rates not likely to vary) more likely drop-out from health care system after one visit.

For those that sought care, there was no difference in delay in seeking care between wealthy and poor groups. However older age groups were more likely to delay seeking care. Care outside the household was sought for youngest age group (<5) and 16-30 age group more frequently than other ages. This did not vary by gender.

Furthermore, for those that did seek care, respondents from poor households (54%) more often reported visiting a public health centre than those from rich households (50%), though this difference was not statistically significant. Visiting a missionary facility was reported more often by those from rich households (23%) compared to those from poor households (19%), though, again, the difference was not statistically significant. Aside from the numbers visiting public health centres and missionary facilities, respondents from wealthier households were significantly more likely than poor households, to visit a private facility and go to hospital, whereas, poorer households were significantly more likely than rich households, to visit a private pharmacy and a traditional healer

- ***Are there big differences in results between cash rich and cash poor regions?***

A significantly larger proportion of households in Gitega, compared to Mwaro and Muramvya, were classed as being 'poor'. Furthermore, Gitega had significantly more respondents with no formal education, more of these being males and proportionally more households were male only headed.

The prevalence of illness varied significantly across provinces with Gitega reporting higher illness rates (20%) than Mwaro (14%) and Muramvya (15%). However this difference could not be explained by differences in socio-economic status, as the prevalence of illness did not vary significantly by quintile group. Though, it should be recognised that areas where food production is lower may have higher associated level of illness. Significantly more households in Gitega (59%) reported having at least one member who had been ill within the recall period. However, the burden of illness did not vary significantly by province or socio-economic group.

Significantly fewer respondents in Gitega, as a proportion of those ill, sought care outside the household (73%) compared to other provinces and households in Gitega sought health care outside the household for proportionally fewer members. The choice of facility also varied significantly across provinces. In the provinces of Gitega (54%) and Mwaro (68%) respondents more often visited public health centres, followed by private pharmacies in Gitega (15%), and private health clinics/hospitals in Mwaro (14%). In Muramvya respondents were less likely to visit public health centre (34%) and more likely, than respondents from Gitega and Mwaro, to visit missionary facilities (46%) and public hospitals (9%).

In terms of health care expenditure, the largest component was spent on drugs (49%). This was significantly greater in Gitega, followed by Mwaro, and lowest in Muramvya, and was also proportionally greater in expenditures among poorer groups in poorer. Following this, the proportions spent on food and outstanding money owed to facilities

make-up the next largest components. Highest expenditure is incurred in public hospitals where proportionally most of these costs are spent on food. As a proportion of total expenditure, the amount outstanding (i.e. debt incurred) is significantly greater in missionary and public health facilities.

- ***Is distance or cash availability more of a problem in some areas than others?***

Cash availability across all those surveyed was low. Only 10% of respondents who work receive cash remuneration for employment undertaken. Average per-capita consumption is 38,013BIF (45USD) and consumption levels in over 60% of households are under the $1 a day level. This compares to the proportion of the population living in extreme poverty in Burundi (proportion of population below $1 a day) recorded as 36.2% in 1999 (World Bank[c]). Gitega reported significantly larger proportions households in poorer groups. Though evidently even those in 'wealthier groups' are classed as being poor. Poverty was repeatedly cited as the most common reason for restricting access to health care. However, there was no variation in the proportion of debt incurred for health care visits across all socio-economic groups, suggesting that all groups struggle with the costs of health care.

For those that chose not to seek care outside of the households, the decision to not seek care did not vary significantly by type of illness. Distance was not rated as a significant barrier in seeking care, and the distance from the household to health facilities was not significant in the initial decision to seek care (i.e. barrier in accessing care). Most respondents (95%) lived within 1km of a health centre (public or private). The most often (34%) cited reason for not seeking care outside of the households was that they 'could not afford to at the time'. However, the choice of the type of facility visited, varied significantly with the distance of a private pharmacy and public hospital from the household (i.e. barrier to utilising care).

- ***How does cash availability within households (intra-household resource allocation) change health care expenditure patterns?***

A large proportion of households shared equal head of household status. Though there was evidence from the FGD's that, although men and women shared equal decision-making power, the men controlled the money. As well as working their own land, males were more likely to be employed in other jobs where they were paid in cash. It was also males' responsibility to find the cash when health care was sought and to pay off any health care debts. All these factors may impact on who seeks health care within the household (which is reflected in the expenditure patterns).

However, no significant differences were found in expenditure patterns between young age groups all other age groups, except those in the over 50's age-group (where spending is significantly higher). This suggests that health care costs do not vary between children and adults. Total health care expenditure does not vary significantly between gender groups. Moreover, proportionally, variations in expenditure by cost category do not vary statistically, though drugs expenditure is slightly higher for women.

- ***How do household assets change health care expenditure patterns? How did the poorest quintile cope compared to others, and does this suggests riskier coping strategies?***

There is evidence to suggest that poor households have fewer coping strategies to cope with the costs of illness. A significantly large proportion (18%) of households in poorer groups have no coping strategy for paying health care costs. Those that do, rely heavily on selling assets (55% and 61% in the poorest two quintile groups) or borrowing money from a friend or relative (22% and 35% in the poorest two quintile groups) to cover health care costs. These are risky, irreversible strategies and are potentially catastrophic for already poor households who may not be able to recover the costs that they have to pay out or cope when more than household member falls ill, or a household member for whom money was outlaid, dies. Within the FGDs respondents worried about needing to sell already depleted assets. Concerns were raised over the problems of the trade-offs of paying for health care of one household member at the expense of feeding the entire households, being able to treat other household member in the future, or paying out for care and the person dying (in which case you would lose both your assets and a household member and neither could be recovered). Additional 'safety-nets' such as reducing household expenditure or using household savings are not common among this poorest group.

Although wealthier groups also most commonly sell assets (58% and 44% in the wealthiest two groups) and borrow for friends or relatives (25% and 25% in the wealthiest two groups), proportionally more households in wealthier quintile groups tend to have more than one strategy for coping with health care costs. As well as selling assets and having stronger borrowing power, they are more likely than poor households to use household savings and reduce their household expenditure until bills are paid.

Few people appear to save explicitly for to cover future health care costs. There was an example of a savings scheme in Mwaro, though this was not specifically aimed at health.

B. IMPLICATIONS OF RESULTS

The results highlight the current problems exiting between groups in accessing and utilising health care services:

1. Age and gender inequalities

- Although older age groups tended to report a significantly greater prevalence of illness, they were more likely to delay seeking health care. Delay may be due to the greater expenditures incurred in seeking health care among the oldest age groups, suggesting that the costs of seeking health care are greater for elders.

- It is important to note that the results indicated that the health care expenditures did not differ significantly between children and other age groups (except for those over 50), suggesting that the health care costs incurred in seeking health care for children were equivalent to those for an adult (an issue also raised in the FGDs). However, there was

no clear evidence that this leads to under-utilisation of health care among children and there is no difference among the youngest group (<5) in utilisation between gender groups.

- Although illness prevalence was significantly higher for females in all age groups (except the under 5s), utilisation did not vary by gender. Since the data was all reported over same time frame, this raises the issue of whether females are under-utilising health care. Under-utilisation may be related to intra-household resource allocation, as men tended to control the household money. Other suggestions are that males may under-report the prevalence of illness, (in doing so it falsely appears as if males are over-utilising health care), or females may utilise health care more rationally.

- There is evidence that health care outside of the household cannot be sought for all household members who are ill. On average, where a household reported the prevalence of illness (i.e. where at least one member being ill), there was usually more than one household member ill at the same time. Poor households sought health care outside of the household for proportionally fewer household members than wealthier households. Given the potential under-utilisation among women and elder household members, it appears that these groups may have sacrificed seeking care outside of the household in order that other household members could; i.e. older members, and women in particular, are making sacrifices for the young.

2. Socio-economic and geographical area inequalities

- The prevalence of illness did not vary significantly among socio-economic groups; yet, poorer groups were more likely not to seek care outside of the household, perhaps indicating under utilisation by poorer groups. This is further evident when analysing second health care visits, which show that, given all else being equal, individuals from poorer households are less likely to remain in the health care system, i.e. more likely to drop-out of the health care systems after one visit.

- Similarly, Gitega (the province where, comparatively, a significantly large proportion of households were classed as being 'poor') reported higher prevalence of illness and lower utilisation rates than other provinces.

- Distance was not highlighted as a significant barrier in accessing care, rather, poverty – not being able to afford to do so at the time – was given as the main reason. On the other hand, distance did become a barrier in utilising specific types of health care, particularly hospitals and private pharmacies.

- Wealthier groups tended to experience better quality services. The reasons for this are two-fold, they more frequently visited facilities where quality was ranked more highly (private and missionary facilities), and when accessing public facilities (where quality was ranked as poor, wealthier individuals, were either treated differentially, or could afford to pay incentives so as to receive more prompt, better quality treatment.

- Health expenditure was absolutely greater among wealthier groups, due, in part, to the fact that they visited facilities which incurred the highest expenditures (sometimes in-line with quality). However, in relation to annual consumption, health expenditure

impacted more greatly upon poor groups, spending proportionally more on health care than those in wealthier groups.

- All respondents appeared to have problems in coping with health care expenditures, this was evident in the reported amounts of money that was still owed to facilities. Most respondents had to sell assets and borrow from friends or relatives. Though, poorer groups had fewer coping strategies than wealthier groups, and often relied on risky, irreversible strategies.

3. Impact of protection mechanisms

- Only twenty-nine percent of respondents possessed some form of pre-payment insurance. This was mainly comprised of those possessing the CAM card (20%). Wealthier groups were more likely to be covered by some form of pre-payments card and the proportion covered by MFP cards was greater among wealthier groups. Similar results were found for poor areas such as Gitega, where possession of pre-payment insurance was lower than other provinces.

- The details of pre-payment card ownership were confused, in terms of who needed to purchase which type of card, which facilities you were entitled to use, and the discounts you were eligible for.

- MFP cardholders can use their cards at missionary hospitals and public hospitals (largely through out-patient departments). Higher expenditures were incurred through both these types of facilities. This is consistent with expenditures incurred by MFP card-holders and also explains why wealthier groups more frequently than poorer groups, reported visiting missionary facilities and hospitals. However, it is not clear whether MFP card holders are paying more for health care because they can afford to, they are accessing better quality services, or they are using their cards to obtain more expensive treatments that they would utilise if not covered by the scheme – a phenomenon referred to as price and moral hazard effect.

- CAM cards are accepted at public health centres where quality is poorly rated. The expenditure for CAM cardholders were found to be equivalent to those reported by individuals who did not posses a card. This was true for all provinces. A number of explanations may exist. Cardholders may not be receiving the full discount that they are entitled to. Respondents reported being unaware of what they were being charged for or not knowing the prices, in turn they will unaware when they over-charged. Also, as above, cardholders may be paying for more expensive treatments (because they have the card).

- In Muramvya, where all care at public health centres was in principle free for all, the fact that respondents were reporting health expenditures, albeit to a lesser extent than other provinces, may imply some illicit charging may be taking place or indicate that individuals are also having to purchase services from elsewhere. Furthermore, these expanses may be associated with the costs of the type of care are most commonly sought in Muramvya (seeking care at missionary facilities and public hospitals were most common, and significantly more common than in Gitega and Mwaro provinces) where services were not provided free of charge.

- In terms of the financial features of the pre-payments cards, cardholders appeared to be more likely to utilise health care services outside of the household. In financial terms this points to a moral hazard effect – where people over-utilise health care services simply because they know they are covered to a certain level. However, since utilisation rates are still comparatively for cardholders, it may also suggest that accessing care was easier for cardholders, or it may indicate that individuals are simple purchasing the card as they become sick in order to cover the treatment they require.

- Only ten percent of our sample was aware of the existence of any exemption mechanism whereby individuals could be exempt from paying the full costs of health care, and, of all the respondents who were ill and sought health care, all contributed towards health care costs, suggesting that none were exempt. However, the numbers of people reporting being unable to afford pre-payment cards (because they could not afford to), and thereby being unable to access and utilise care (also see above: reasons for not seeking care), indicated that even the poorest groups are not receiving the exemption status they are entitled to. Reasons for this, highlighted through the additional qualitative interviews, indicated that wealthier groups could claim exemption status when they may not be entitled to. There was also little protection against coping with debt. Those who could not pay off medical bills were often not allowed to seek care (for themselves or other member of their family) at that facility until the debt was paid, and others could face 'medical jailing', whereby they were jailed for non-payment.

4. Summary

In summary, the current pre-payment insurance and exemption mechanisms do little to offer protection against the impact of user fees or reduce the inequalities outlined above. Under the existing arrangements, the CAM card virtually acts like an entitlement card – a one off payment that allows the holder to access the services that they can afford to. given that the poor cannot afford to purchase the card they do not receive such entitlements and thereby, utilise care more infrequently or incur debt.. Furthermore, the scheme may not be financially viable. Sub-optimal levels of membership mean that there is little scope for risk-pooling, and hence insufficient funds to pay for member services. In addition, it is subject to the affects of moral hazard, particularly 'price' moral hazard effects, and payments and reimbursements are not retained within health sector. It is difficult to see how user fees and the money raised through the sale of CAM cards is effectively fed back into system. Figures based on the current system, where any revenue generated is handled by the commune administration, indicate that the public health centres retain only 1% of user fees collected. Facilities may view cost-recovery on user charges as the only means by which to keep to the service running, thereby encouraging the risk of in-effective use of services (promotion of more expensive services), deterring access for poorer groups.

5. Comparisons with international and regional experience

These observations are in-line with the majority of international evidence and experience of other countries in the region, (e.g. Bamako Initiative) (Conn and Walford, 1998; Kivumbi and Kintu, 2002; Nyonator and Kutzin. 1999; Meuwissen 2002; Kipp *et al* 2001;

Bennett and Gilson, 2001; van der Geest *et al* 2000; Russell, Abdella, 2002.) which has shown that:

- User fees limit access and deter utilisation. In virtually all cases where user fees were increased or introduces there has been a concurrent decrease in service utilisation…and they [user fees] are likely to act as an additional deterrent to accessing care (especially for the very poor) (Bennett and Gilson, 2001). Furthermore, where facilities are allowed to retain revenue generated, wealthier areas are more likely to raise more revenue than poor areas, and so lead to differential health care provision (increase inequalities).
- User fees at the point of service, tend to encourage delay's in seeking care and lead to the onset of more serious and expensive illness.
- Often, direct payment (user fees) and pre-payment schemes tend to be regressive: the amount a person pays is not dependent upon their income and the poor are more adversely affected. Moreover, the financial burden falls upon the sick, who are also often the poor.
- User fees may encourage facilities to provide what people are willing to pay for – often excessive diagnostic tests and drugs.
- Both user fees and pre-payment schemes that cover individuals rather than households, require intra-household prioritisation of resources which can often mean that certain members (often boys, men) are given priority in obtaining care over other household members (often women, girls, elderly).
- Low household income levels mean that revenue-generating potential of user fess in low income countries is low, limiting the scope to improve quality and accessibility. Given the amount of resources required to administer the fee collection systems, the amount of supplemental funding made available is even less.
- Where families do manage to pay, there may be wider implications on the household economy – in terms of reduced consumption other consumption goods, indebtedness, or household impoverishment.
- Where exemptions exist, they often do not protect the poor but, rather, they benefit the more wealthy groups.

C. ADDRESSING THESE IMPLICATIONS

1. The role of risk sharing

The apparent inability of the current CAM scheme to offer social protection to the poor against the impact of rising user fees imposed for the purposes of cost-recovery raises the issue of how the poor and seriously sick can be assured access to adequate treatment and be protected from the potentially catastrophic economic losses that may result. This underscores the potential need for risk-sharing, whereby identified populations share the risks and costs of health care (Bennett *et al*, 1998). However, given the existence of the CAM scheme, it would seem superfluous to establish a new system, rather the current scheme can be re-orientated:

- Insurance should be provided in addition to a basic package of essential services which should be funded by the government and be provided free of charge. The type and level of essential services depends on the amount of government of funding available. It is important to note that establishing even a basic package of care requires an enormous amount of economic resources. As a starting point, health care services provided for certain disease areas such as HIV and TB care, maternity services, or malaria care for the under fives may constitute the essential package. Additional services and items can be funded through the insurance card.

- The card should enable individuals or households[44] to make an annual pre-payment that would entitle them to a certain level of free services. Some limits can be placed on the amount of treatment covered. In Burundi, immediate changes to the pre-payment scheme should aim to restrict the total costs, perhaps by initially restricting, high cost items, so one could limit number or type of prescriptions or drugs prescribed, for example, but allow unlimited consultations.

- Over-time limited items that fall into the insurable category, such as hospital stays, can be added to the scheme. Additional packages or enitilements to certain services can then be purchased through pre-payment insurance. Examples of such schemes that operate on a small scale are Zambia, Tanzania, Uganda. Moreover, drawing on the experiences of the example of pre-payment insurance in Rwanda, may be an appropriate starting point[45].

- An effective exemption scheme is needed. Free or subsidised cards should be given to the poor. This would involve, those entitled to exemption needing to only claim once for the card, after which they would obtain treatment in the same way as everyone else. Alternatively, exemption for specific types of care can be issued through voucher schemes. Instead asking people to prove that they are entitled to exemption status, which is difficult to do and open to interpretation and corruption, vouchers for entitlement to specific types of care, can be targeted to specific groups of people: e.g. targeting groups such as women, children (i.e. free care or types of care for all <5's) or disease groups. A more comprehensive system that has been previously suggested is community-based wealth ranking (Russell and Abdella, 2002).

2. The role of government and donors

The role of the Ministry of Health is crucial, as a regulator, in the functioning of a health care financing system. The government needs to recognise the importance of spending

[44] The concept of risk may be better addressed at the household level in order to strengthen the ability of the household to cope with the economic costs of illness. (Sauerborn *et al*, 1996).

[45] In Rwanda, the benefit package for pre-payment schemes was defined by the community. On paying an annual premium per family to enrol to the scheme, members are entitled to, fater a one-month waiting period (prevents members joining only when they are sick) , to a basic package covering all services and drugs provided in their preferred health centre (a nominated – preferred provider can be subject to inspection). A co-payment is levied at each health centre visit. Risk pooling for the health centre package takes place across the catchment area for the health facility and providers receive a monthly capitation payment for each member. Results from the pilot testing of the system have shown that the pre-payment plans have been a viable method to improve both providers' productivity and sustainability in health care financing, while providing better access to care for the poor (Schneider. P *et al, 2001).*

on health and health care, and its affects on the whole economy (Sachs, 2001). In-line with any changes that may be made to the current cost-recovery or pre-payment scheme, the ability or legitimacy of the role of central and local governments in controlling funds raised through scheme should be taken into account:

- If the local administration are supposed to undertake the job of collecting and administering the revenue collected through the sale of cards, they need to increase capacities at commune level to manage funds, keep the money in the health service, and reimburse facilities where and when discounted care is given.

- One option would be that the government takes a hands off approach but encourages local schemes to develop with help of NGOs. The government then negotiates with donors for funding to subsidise exemption schemes which can cover those on low incomes.

- Alternative options are for existing organisations to take control of these funds, for example community church groups[46] (Green *et al*, 2002), co-operatives, micro-credit organisations, or individual health centres (e.g. mutual health organisations-specifically organised around health (Atim, 1998), or ILO STEP programmes). . Obviously any one of these will exclude certain groups (as they are linked to social boundaries, geographic boundaries, or local labour boundaries). It is important that the government is aware of this problem and alternatives are found for those not covered by any of the schemes employed.

- Additional safety-nets to protect the poor against the potential catastrophic costs of illness, also extend beyond the health sector. Micro-finance and savings schemes (e.g. rotating savings and credit associations (Kimuyu. P.K, 1999)) increase the potential for people/households to borrow and save money.

- However these schemes are managed, they are not likely to be self-financing insurance schemes and should not be viewed as sustainable methods of health care funding. Government and donor money needs to be put into these schemes to maintain and sustain them.

3. Organisation and regulation

Government and donor agencies need to remain committed to increased public funding for health care. The revenue generated through user fees is and will continue to be limited. However, given the principles underlying the establishment of user fees in Burundi, they are likely to remain. The adoption of any new insurance schemes need to be considered within a wider, comprehensive health care financing sector strategy, focussing on how fees can be more equitable or pro-poor. This requires:

- Increasing public sector funding for health services. The realisation that user fees will not be able to significantly increase financing for the health care sector means that both the government and donors need to increase funding. The WHO's Commission on

[46] This is, of course, the way insurance started in Europe. Social capital is also likely to be strong since people are likely to have close links with each other both to care for and also reduce the danger of excess use

Macroeconomics and Health argues that developing countries need to spend US$30-40 per-capita in order to provide a basic package of health services. This compares to the current level of government spending which is estimated to be US$0.7 per-capita and average ODA to the health sector in Burundi which was estimated as US$0.9 per-capita.

- Strengthening the role of the government to act as a regulator to overcome the existence of market failure in the health system. This includes building/extending bureaucratic control through organisational and regulatory systems (judicial systems) to handle contractual arrangements and manage the market for providing health services through the introduction of appropriate incentives.

- Investments in capacity and infrastructure. In order to succeed in implementing any insurance scheme, effective billing and collection mechanisms, record keeping, financial accounting and banking systems, need to be in place.

- The management of revenue from users fees needs to be transparent. All staff should be aware of the fees and procedures for retaining fees systems, which should be clearly defined. Any money raised through the health care system at this level should remain within the system, and controlled at this level (through government subsidies will be required for predominantly poor areas where low revenue is generated). In this way, improvements in service quality (e.g. improvements in staff motivation) can be brought about.

- Prices and charges need to be regulated. Policy should be designed so that the fees are 'affordable'. And a clear policy for exemptions should be defined. Again these should be closely monitored.

- Education. The communities should know of their rights and entitlements, such as who is eligible for exemption, the benefits of purchasing a card, etc. They should know what they are paying for, the prices and charges should be made clear up-front, e.g. through posters in the health care centre, for example.

- A sense of community ownership. community management structures and community participation in the organisation of health funds or local level facilities, promote and establish confidence between staff and community.

D. CONCLUSION

In order to raise finance for the public health care systems, the Burundian government adopted a cost-recovery policy which involved recovering either 100% or 20% of costs of health care provided, through user fees at the point of service delivery; and collecting revenue generated from the sale of pre-payment 'insurance' cards. The revenue generate through user fees is limited and no evidence that the money raised through sale of pre-payment cards remains within health care system.

The evidence presented from this research indicates that the majority of people are unable to afford the high costs incurred when seeking health care. This results in inequalities in accessing and utilising health care between age and gender groups, and

socio-economic and geographical areas. Moreover, the current pre-payment schemes, with particular focus on the CAM, do not appear to offer protection against the impact of user fees, nor does there appear to be an effective exemption system.

Given this, the government and donors need to look at alternative options within a wider, comprehensive health care financing sector strategy, focussing on how fees can be more equitable or pro-poor. Actions need to include:

- increasing public funding for the health sector
- reducing to user and drug charges to 'affordable' levels
- investing in alternative sources of funding through risk-pooling and health insurance initiatives
- focusing on equitable provision of health care
- introduce effective exemption mechanisms and explore the advantages and feasibility of introducing additional economic safety-nets (micro-finance schemes and credit associations).

As a starting point, given the existence of the CAM scheme, it would seem superfluous to establish a new system, rather the current scheme can be re-orientated. Issues that will need to be addressed include: how the insurance scheme will be managed and administered, how communities be empowered via the schemes., what people are able and willing to pay for; how central government will contribute, and what will they contribute (finance, HR, legislation, regulation, training).

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V. ANNEX 1: Study outline and terms of reference (TOR)

STUDY OUTLINE

Coping with Community Health Financing Scheme:
Illness costs and their implications for poor household's ability to pay for health care, and children's access to health services

A Study by Save the Children Fund UK

Background

Poor and vulnerable groups are already facing difficulties in accessing health services. Although drug prices at government facilities have not increased dramatically over the last five years, facilities are often understaffed and experience drug shortages. Consequently patients cannot obtain drugs, or must buy drugs from private pharmacies at high prices. Alternatively they may increasingly be relying on traditional practitioners and self-treatment.

Burundi has been undergoing civil conflict since the crisis of 1993. This has resulted in large displacements of population both inside Burundi and over the borders of neighbouring countries. The uncertainty of the economic situation as a result of both the internal conflict and limited allocation of resources in the health sector has affected the population's livelihoods and the ability of the Ministry of Health (MoH) to provide basic primary health care services. Coupled with this is the limited financial resource allocation by the transition government to the health sector (4.7% of total government expenditure per year) lowest as compared to all other public services. In addition donor funding to the Ministry of Health has been reduced to a negligible amount resulting in a near collapse of the public health system. As a consequence access to health services for much of the population, especially the most vulnerable groups, women and children, has been severely restricted. Introduction of cost recovery is part of the Burundian government's health sector strategy. However, there is concern about the potential impact of charging users higher prices at government facilities, especially among poor households and children. There is also concern about how the seasonal availability of cash affects health-seeking behaviour and feasibility of determining an appropriate pricing structure and safety nets.

Save the Children UK Burundi Team with the help of a consultant will conduct the study, planned for six weeks, in collaboration with the MoH and other stakeholders. Technical support will be sought as appropriate from the SC-UK based Senior Health Advisor and Regional Health Advisor at Nairobi.

Aims of the study

The principal aim of the study is to determine the feasibility of introducing a sustainable community health-financing scheme in two rural provinces in Burundi. This should also enhance the identification of an appropriate pricing structure and safety nets. The specific objectives are:

1 (a) To evaluate the impact of (i) financial costs of illness and (ii) time costs of seeking treatment on poor household's ability to pay for care, and children's access to services.
(b) To evaluate the implications of (i) financial costs of illness and (ii) production or wage losses due to illness on household livelihoods (assets, debts and social obligations).
(c) To evaluate the impact of any new cost recovery policies on household ability to pay for health care and children's access to health services.
2. To evaluate the relationship between cost recovery policies and quality of health services.

3. To identify factors that make individuals or households resilient or vulnerable when faced with illness, including:
   (a) strengths and weaknesses in health service delivery arrangements and charging and exemption systems,
   (b) the role of social resources and access to credit,
   (c) decision-making within the household and intra-household resource allocation patterns.
4. To propose alternative policy options that will reduce exclusion from health services for children from poor households.

Hypotheses

(a) Geographical access

- In peripheral or inaccessible areas, the costs of transport (time and financial) are a greater barrier than the costs of drugs and other medical inputs, and prevent access to public health services even when services are free.

(b) Socio-economic groups

- Children and women have less control over household resources so are less able to pay and face greater access barriers than men.
- Poor households have fewer material assets and lower social resource endowments, so have fewer strategies available to cope with the costs of illness.
- In most months poor households have no cash available for any form of treatment or illness cost, and so have to adopt cost prevention strategies (no treatment) or risky cost management strategies (alternative cheaper providers, borrow, asset depletion, draw on social resources).
- Traditional mechanisms of social security can mitigate the indirect costs of illness caused by incapacitation, and contribute to health care financing for all households; they therefore make them more resilient to illness costs.
- For better-off households the financial costs of illness will increase over three years due to cost recovery policy, increasing drug shortages at public facilities and therefore increasing use of private sector providers.
- For poor households, the financial costs of illness will decline over three years due to cost recovery policy and increasing drug shortages at public facilities (deterring utilisation), and therefore increasing use of traditional providers or self-treatment.

(c) Seasonal and annual variability

- The direct and indirect costs of illness, and therefore access to services, vary significantly between seasons: they are lowest at pre-harvest ('hungry') times or busy times in the agricultural calendar; and highest just after a harvest when more cash and time are available.
- Seasonal variations in access to cash and opportunity costs of seeking treatment influence illness costs more than seasonal variations in illness (prevalence).

Funding

The study will be funded entirely by Save the Children UK. However, other support will be sought as found appropriate. The total cost of study is estimated at GBP18,000

TERMS OF REFERENCE

SAVE THE CHILDREN UK: TECHNICAL SUPPORT TO COPING WITH COMMUNITY HEALTH FINANCING SCHEME RESEARCH

Background

Save the Children UK intends to conduct a study in Burundi titled: "Coping with a Community Health Financing Scheme": Illness costs and their implications for poor household's ability to pay for health care, and children's access to health services".

The aims of the study are:

1. (a) To evaluate the impact of (i) financial costs of illness and (ii) time costs of seeking treatment on poor household's ability to pay for care, and children's access to services.
   (b) To evaluate the implications of (i) financial costs of illness and (ii) production or wage losses due to illness on household livelihoods (assets, debts and social obligations).
   (c) To evaluate the impact of any new cost recovery policies on household ability to pay for health care and children's access to health services.
2. To evaluate the relationship between cost recovery policies and quality of health services.
3. (a) To identify factors that make individuals or households resilient or vulnerable when faced with illness, including: (b) Strengths and weaknesses in health service delivery arrangements and charging and exemption systems, the role of social resources and access to credit, decision-making within the household and intra-household resource allocation patterns.
4. To propose alternative policy options (safety-nets) that will reduce exclusion from health services for children from poor households.

The study will be conducted as a cross-sectional study in Gitega and Mwaro provinces. Data collection is expected to last two weeks followed by two weeks data entry and analysis by hired consultant. Final report should be produced on or before the end eight week from date of commencement of consultancy. The consultant must provide a draft report by the end of the sixth week.

Purpose

The purpose of the consultancy is to provide evidence-based information on the feasibility and identification of an appropriate framework for the introduction of a community health-financing scheme.

Specific Objectives

The consultant will:

1. Be the principal investigator and analyse the data set using an appropriate statistical tool/software in order to better answer the following questions:

   - How was illness distributed over households – was it concentrated in a small proportion of households or spread quite evenly?
   - Do we think there was under-reporting of utilisation of traditional healers
   - How did treatment response vary by type of household or individual?

- How did treatment response vary by social / age / gender groupings? Why?
- Are there big differences in results between cash rich and cash poor regions?
- Is distance or cash availability more of a problem in some areas than others?
- How does cash availability within households change health care expenditure patterns?
- How do household assets change health care expenditure patterns? This is meant to include allocating households to asset categories and doing more detailed analysis of treatment seeking, costs of illness and coping by household socio-economic or asset group. How did the poorest quartile cope compared to others, and does this suggests riskier coping strategies?

2. Using the qualitative data ensure that all the qualitative results are adequately incorporated in the report so as to compliment the quantitative analysis. If possible, and dependent of the availability of time and English translations of the original French transcripts, additional analysis could be done on the qualitative data as follows:

    - More comparison of the views of men and women on the same subject (e.g. do men and women have different views about treatment, decision-making etc).
    - More comparison of the views in each site (e.g. do women from Gitega have different views or difficulties than those in Mwaro, or the same?) Why?
    - More quotes to illustrate each point that is made.
    - For key issues, more emphasis and more detailed descriptions of what people said, for example about cash availability and months when there are cash shortages.
    - Some diagrams to summarise what people said, for example for treatment seeking behaviour are there patterns / sequences of treatment (action 1, then action 2) that can be mapped out? Do these vary from area to area – in the report it suggests that this is the case.

It must be emphasised that additional qualitative analysis listed above is dependent on the consultant having both the time within the 40-day framework of the contract AND English translations of the original French transcripts.

Outputs

The consultant will produce report, suitable for distribution to policy makers, on the study “Coping with community health financing scheme”. The end of the sixth week and a final report should provide a draft of the report not later than the eight week from commencement of contract. The final report can be submitted electronically to the Save the Children Burundi office by 6th September 2002.

Time Scale

The consultant will bill Save the Children for the actual number of days worked, not to exceed a maximum of five months between 8th April 2002 until 6nd September 2002.

VI. ANNEX 2: Training schedule / timetable (French)

PROGRAMME POUR LA FORMATION DANS LA PROCEDURE DE COLLECTE DE DONNEES (ENQUETEURS)

10 MAI – 14 MAI 2002-05-09

JOUR	DATE	THEMES	HEURE	FACILITATEUR
Vendredi	10/05/02	Exercice d'une enquête sur un ménage	8.30-5.30	Daniel Angela
Samedi	11/05/02	Exercice de groupe sur enquête	9.00-16.00	Daniel Angela
Dimanche	12/05/02	Supervision et suivi - pratique - techniques - qualités Discussions sur le pré-test	10.00-12.00	Daniel Angela (seulement pour les superviseurs)
Lundi	13/05/02	Tester le questionnaire	8.00-16.00	superviseurs
Mardi	14/05/02	Feedback sur le questionnaire Finalisation questionnaire et les consignes sur le entretiens de groupes Finaliser les arrangements pour la répartition des équipes Evaluation Clôture Réception Cocktail	8.30-12.00 14.00-15.00 15.00 16.00 17.00 18.30	Daniel Angela Superviseurs Mathias Mathias Sylvestre
Mercredi - Vendredi	15/05/02	Collecte des données		Superviseurs

VII. ANNEX 3: Household sample codes for household survey.

HOUSEHOLD CODES

PROVINCE	(P)	COMMUNE	(C)	ZONE	(Z)	HOUSEHOLD NUMBER					
GITEGA	G	GIHETA	1	KABANGA	1	G	1	1	01	TO	32
GITEGA	G	GIHETA	1	KIRIBA	2	G	1	2	01	TO	32
GITEGA	G	GIHETA	1	GIHETA	3	G	1	3	01	TO	32
GITEGA	G	GISHUBI	2	NYABIRABA	1	G	2	1	01	TO	23
GITEGA	G	GISHUBI	2	MUGARURO	2	G	2	2	01	TO	23
GITEGA	G	GISHUBI	2	NYABITANGA	3	G	2	3	01	TO	22
GITEGA	G	GITEGA	3	GITEGA URBAINE	1	G	3	1	01	TO	35
GITEGA	G	GITEGA	3	GITEGA RURALE	2	G	3	2	01	TO	34
GITEGA	G	GITEGA	3	MUNGWA	3	G	3	3	01	TO	35
GITEGA	G	GITEGA	3	MUBUGA	4	G	3	4	01	TO	34
GITEGA	G	MAKEBUKO	4	MURENDA	1	G	4	1	01	TO	32
GITEGA	G	MAKEBUKO	4	MARAMVYA	2	G	4	2	01	TO	32
GITEGA	G	MAKEBUKO	4	MAKEBUKO	3	G	4	3	01	TO	30
GITEGA	G	MUTAHO	5	MUTAHO	1	G	5	1	01	TO	42
GITEGA	G	MUTAHO	5	RWISABI	2	G	5	2	01	TO	42
GITEGA	G	NYANSANGE	6	MURAMBI	1	G	6	1	01	TO	17
GITEGA	G	NYANSANGE	6	BUKORO	2	G	6	2	01	TO	17
GITEGA	G	NYANSANGE	6	NYARMSANGE	3	G	6	3	01	TO	16
										TOTAL	530
MURAMVYA	M	KIGANDA	1	KIGANDA	1	M	1	1	01	TO	61
MURAMVYA	M	KIGANDA	1	GATABO	2	M	1	2	01	TO	61
MURAMVYA	M	KIGANDA	1	KANYAMI	3	M	1	3	01	TO	60
MURAMVYA	M	MURAMVYA	2	MURAMVYA	1	M	2	1	01	TO	69
MURAMVYA	M	MURAMVYA	2	SHOMBO	2	M	2	2	01	TO	69
MURAMVYA	M	MURAMVYA	2	RYARUSERA	3	M	2	3	01	TO	69
MURAMVYA	M	RUTEGAMA	3	RUTEGAMA	1	M	3	1	01	TO	70
MURAMVYA	M	RUTEGAMA	3	MUSHIKAMO	2	M	3	2	01	TO	70
										TOTAL	529

PROVINCE	(P)	COMMUNE	(C)	ZONE	(Z)	HOUSEHOLD NUMBER					
MWARO	R	BISORO	1	BISORO	1	R	1	1	01	TO	24
MWARO	R	BISORO	1	KANGA	2	R	1	2	01	TO	24
MWARO	R	BISORO	1	RORERO	3	R	1	3	01	TO	24
MWARO	R	GISOZI	2	GISOZI	1	R	2	1	01	TO	26
MWARO	R	GISOZI	2	NYAKARARO	2	R	2	2	01	TO	27
MWARO	R	KAYOKWE	3	GATWE	1	R	3	1	01	TO	22
MWARO	R	KAYOKWE	3	MUYEBE	2	R	3	2	01	TO	22
MWARO	R	KAYOKWE	3	MWARO	3	R	3	3	01	TO	21
MWARO	R	KAYOKWE	3	KAYOKWE	4	R	3	4	01	TO	21
MWARO	R	NDAVA	4	NDAVA	1	R	4	1	01	TO	59
MWARO	R	NDAVA	4	BUZIRACANDA	2	R	4	2	01	TO	59
MWARO	R	NYABIHANGA	5	KIBUNGERE	1	R	5	1	01	TO	39
MWARO	R	NYABIHANGA	5	MUYANGE	2	R	5	2	01	TO	39
MWARO	R	NYABIHANGA	5	NYABIHANGA	3	R	5	3	01	TO	38
MWARO	R	RUSAKSA	6	MAKAMBA	1	R	6	1	01	TO	42
MWARO	R	RUSAKSA	6	RUSAKA	2	R	6	2	01	TO	42
										TOTAL	529

VIII. ANNEX 4: Household questionnaire / training manual

BURUNDI:

Household Questionnaire on Health Expenditures and Perceptions 2002

Instruction Manual for Interviewers

INFORMATION FOR INTERVIEWERS

Aim of the Survey

The aim of this survey is to find out more about how, why and when people in Burundi access health care services and how much they spend in doing so. It also aims to find out more about why certain people do not access health care services when ill and how decisions on whether or not to seek health care advice/treatment from outside the household are made. In addition, the survey aims to find out more about people's perceptions of possible future options for the delivery of health care services in their country.

This type of survey has been undertaken in many areas of the world to date, and this particular survey has been developed in order to provide information for the policy makers in Burundi. Clearly these sorts of surveys can only be undertaken periodically; it is therefore vital we all endeavour to ensure the information we obtain from this survey is as accurate as possible. We are very grateful for your contribution to this important and timely work.

Methodology

The survey is being undertaken in 1588 households across Burundi; 530 households in the GITEGA, 529 households in MWARO, and 529 households in MURAMVYA. The numbers of households have been randomly selected, but have been chosen in such a way to reflect as much as possible, the overall characteristics of the population of the country as a whole.

The overall responsibility for this survey lies with the Save the Children Fund (UK). If you have any queries or difficulties whilst undertaking this survey, please contact the Save the Children Office (Bujumbura) (0217587).

Survey Structure and Design

The survey is divided into five main parts:

- Section A: Household member characteristics
- Section B: Household illness and Exemptions
- Section C: Utilisation of health care (all levels)
- Section D: Household characteristics (income, expenditure and access)
- Section E: Household perceptions of health care services and household decision-making

The survey forms have boxes in which to enter data at the household level and on individual members. Sections A, B and C should be completed for individual household members. Sections A and B require information on all household members. Section C requires information only on members who have been admitted to hospital, consulted a health worker, or purchased medicines or indeed has been ill but not consulted anyone. Section D requires information at the household level including access to services, income and expenditure information, and section E is concerned with the respondent's perceptions (on behalf of the household) of future health service provision and household decision-making.

Sections A&B – Questions on individual household members:

In these two sections, the survey is designed so that a code (01-08) is given to each household member in turn, with the head of the household or main respondent always being household member ☺1, (if there are more than 8 household members, please use the relevant continuation sheet). The questions (A1-A9; B1-B14) are then listed vertically, so that all of the answers relating to a particular member of the household can be found in a single column headed with their unique code.

In the example below there are three household members (☺1, ☺2, and ☺3). Question numbers A2 and A3 refer to the questions about Gender and Age respectively. In most cases the Questions are similar to the 'Gender type' question shown below. The numbers corresponding to the possible response codes given in the question are listed in the column under each household member's number. In each case you are asked to circle the correct number that corresponds to the particular household member (e.g. below, household member 1 is female, household member 2 is male, and household member 3 is also male). In other cases, the question type may be similar to the 'Age type' question shown below. In this case, the answer should be written into the boxes provided, making sure that the answer corresponds to the correct household member and follows the entry instructions carefully (e.g. below, household member 1 is 35, household member 2 is 26, and household member 3 is 6).

		Household Member ☺								
No	Question	☺ 1			☺ 2			☺ 3		
A2	What is their gender? 1. Male 2. Female	1 ②			① 2			① 2		
A3	How old is each member of the household? *(Go through each person in turn and fill in their age in years making sure all three boxes are filled in e.g. if a person is 35 years old, put 035 in the boxes provided. If a child is less then 1 year old, put 001 in the boxes. If the age is not known or disclosed, put 999 in the boxes).*	0	3	5	0	2	6	0	0	6

When respondents simply don't know the answer to a question, a "don't know" code should be circled or entered (this is specified separately for each question in this booklet). Only the specified response codes for each question should be used to complete the boxes on the survey form; under no circumstances should any other information be included.

Section C – Questions on individual household members:

The questions in this section should be answered in the same way as specified above for section A&B. In addition, part way through section C (beginning at question number C16) household members are asked to consider the people / facilities that they sought health advice / treatment from outside of the home. In these questions respondents may have to answer the same questions for each different person / facility they sought advice or treatment from depending on who they saw or where they went first (1st), second (2nd), and third (3rd).

PLEASE NOTE:

In Question C1 we ask the household members whether they have had an illness, injury, or visited a health care facility or health care person in the last month (this is classed as their most recent illness). If they have not had an illness, injury, or visited a health care facility or health care person in the last month, Question C2 asks the household member about the last time they had an illness, injury, or visited a health care facility or health care person (this is then classed as their most recent illness). If the household member has not had an illness, injury, or visited a health care facility or health care person in the last year then the questionnaire tells you to go to *Section D* (as the rest of *Section C* requires information only those household members who have had a recent illness, injury or visited a health care facility or health care person).

In Question C7 we ask about the action the household member took related to their most recent illness, specifically we ask if they sought health care treatment or advice from outside of the household. If the household member did not seek health care treatment or advice from outside of the household we ask for their reasons for not doing so and then the questionnaire tells you to go to *Section D* (as the rest of *Section C* requires information only those household members who sought health care treatment or advice from outside of the household)

Questions C9, C12 and C15 ask the household members about the types of health care facility or people that they visited outside of the household related to their most recent illness. These correspond to the 1st, 2nd, and 3rd columns listed below. If in question C12 the household member responds by saying that they didn't visit a 2nd health care facility or person, then the household member should not be questioned about a 2nd visit and the column for the 2nd visit should be left blank and not fill in the column 2nd).

For the whole of this section we are only concerned with household member's most recent illness (as defined above). They should only mention 1 and all the questions should refer to this most recent illness.

An example of this type of question is shown below:

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.								
		☺ 1			☺ 2			☺ 3		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
	How long did it take the household member to get to the person/facility? 1. Less than 30 minutes 2. 30 minutes to 1 hour 3. 1 to 2 hours 4. over 2 hours 5. over a day 999. Don't know / Refuses to Answer	① 2 3 4 5 999	1 ② 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999

In the question above, it took household member 1 less than 30 minutes to get to the first facility, nearly an hour to get to the second facility, and they didn't go to a third facility. In this section you have to be careful to mark the correct response for the appropriate facility and household member. Specific instructions for certain questions are detailed alongside the questions.

When respondents simply don't know the answer to a question, a "don't know" code should be circled or entered (this is specified separately for each question in this booklet). Only the specified response codes for each question should be used to complete the boxes on the survey form; under no circumstances should any other information be included.

Sections D&E - Questions on the household as a whole:

These questions ask about the household as a whole, and therefore it is only possible for the respondent to give one answer to each question, and only one answer should be coded into the available boxes. An example is shown below. The question refers to the household income. The answer given for this household is BIF 41500.

No.	Question	
	HOUSEHOLD INCOME	
	Can you indicate the total monetary income (salaries and other income) that entered the household in the past month, taking into account every member of the household? *(Try to get an exact amount. If they find this too difficult ask them to make an approximation. Fill in the total amount in the boxes, putting a 0 into any empty boxes, e.g. BIF 23000 = [0][2][3][0][0][0]. If there is no income enter 000000. If they are unsure or are uncomfortable about giving an answer enter 999999).*	**BIF [0][4][1][5][0][0]**

It should be noted at this stage, that although we would ideally like to obtain a picture of the characteristics and perceptions of the entire household, it is clear that the answers given will reflect the individual respondent's perspective most strongly. This will be taken into account in the analysis of the surveys.

Completing survey forms

This survey has been designed to allow each question to have a numbered response. This is to ensure consistency and accuracy between interviewers, and there a number of conditions which should be followed to guarantee the success of this process. It is therefore key that you follow the instructions for asking and recording the response to each question carefully, and follow these overall guidelines as well:

- Please ensure that the unique household identifier code is entered onto every sheet of the interview form. These are located on the first page of the questionnaire and subsequently, the top right hand corner of each page, and consist of 5 boxes. This is necessary to avoid errors on data entry, and to allow checking at later stages in the work.

- Each question has been allocated a defined number of codes, and options for responses. In order to allow accurate analysis of the results of this survey, it is essential that only these codes are circled or entered at each stage. Please ensure that no question contains a code other than that identified in this booklet, and that a code is entered for every question asked. It is important to enter the code when household members refuse to respond, don't know or simple cannot remember in cases such as these DO NOT leave a blank response. For each question asked there should be a response under no circumstances should these be left blank. Blank columns only exist for questions you have not asked.

- If a respondent changes their mind, or an inaccurate code is entered for a particular question, please cross through the inaccurate response with a single diagonal line, and correct the entry. This needs to be as clear as possible to aid accurate and speedy data entry.

Undertaking the survey

Before the interview:

You will be given a set of numbered codes, for the Province, Commune, Zone and individual household. These should be entered in turn for each household where a completed form is produced. In addition you will also be given a unique interviewer code. These numbers will be provided by the Survey Supervisors. You should enter these numbers onto the first page of the questionnaire in the spaces provided and the household code should also be recorded on each page of the questionnaire in the boxes in the top right hand corner of each page.

The process for selecting the households is based on a technique called the 'random walk method'. This method is described below:

- You should select your first household by flipping (tossing) a coin or object where a one side (of the coin or object) represents the choice of approaching the household and the other side represents the choice of going onto the next house. You should toss the coin or object and either approach the house or move to next one depending on the outcome. You will continue to toss the coin or object until you have found your first household.

- From your first house (the point where you have carried your first interview of the day), you should then choose every 5th house from this point onwards. In areas where houses are very widely dispersed you should just choose your directions randomly (as below) and approach the houses that you come across.
- The direction that you turn upon leaving a house is again determined by tossing a coin or object where one side will represent right and the other left.
- When you reach a junction in the path or road, you must again choose which direction to go in randomly by tossing a coin or object where the two sides represent different directions or spinning a pen or pencil.
- If a household that you have chosen using this method is not at home (or not all the household members are present) you should leave a card to state the time you called and arrange a further time that you can come (you will be provided with these). You may have to come to this household at a different time of the day/week to find household members at home. You should then mark the number of times that you have had to come to the house before it was possible for the interview to take place on the front cover of the questionnaire in the space provided. If after 3 attempts of trying to arrange a time for interview it has not taken place, abandon this household and randomly choose another.
- You should begin each new day with this same method.
- It is very important that you do not approach a house whose members you have already interviewed. This may be a possible scenario using this method.

During the interview:

During the interview it is important to gain the trust of the household members. You will be expected to refer to the household members by the numbers you give to them for the purposes of the questionnaire. For ease, you can write the numbers of the household members on a piece of paper and give each member their corresponding number. This may help you and the household members remember their individual numbers.

Always read out the question that is stated in the questionnaire. You should not interpret the question yourself or over simplify the question. We need to be sure that every interviewer is asking the same questions.

Whilst recording the responses of the household members, it is good practice to re-check answers as you go along by using simple prompts such as asking them to repeat a response or returning to questions if need be.

After the interview:

Once the questionnaire has been completed, before leaving the household, each form should be checked to make sure that each question has been answered as appropriate. If there is an inconsistency, please check with the respondent and complete the correct response.

Once the accuracy of the recorded responses has been ascertained, you should leave the household and you should not re-enter the house on this day or any other whilst you are employed to carry out this survey. You should therefore make sure you have all the information you need before leaving the household and once you have left the household, please record the unique household identifier code, the date,

the respondent's name and the address of the household on the separate sheet provided. This data is required to allow the us to check the progress of interviews undertaken, the representativeness of the sample, and to provide a basis for checking that the surveys have been undertaken as requested. Please sign the form at the end of every day, to indicate that the numbers recorded correspond to satisfactorily completed survey forms.

You should then put the completed questionnaire in an envelope provided and seal it. Supervisors will collect all the envelopes and return to the main office for data entry. At the same time you should also give your supervisor your completed interview record sheet on which you have entered the names, addresses, and unique household identifier codes. Under no circumstances should this ever be given to anyone else to fill in or to copy or to hand to your supervisor and you should ensure that you do not lose it.

The success of this survey is dependent on the accurate and timely provision of completed survey forms. In order to allow the data entry process to proceed in a satisfactory manner, it is also essential that the completed forms are returned to your Survey Supervisor on a regular basis.

The timing of this should be agreed with the Co-ordinator, but is set at a maximum of once a week. If there are likely to be any problems, either with returning the forms or achieving the quotas set, please contact your Survey Supervisor as soon as possible, as this survey has a very short time scale.

Household Survey continues over the page:

BASE INFORMATION

INTERVIEWER CODE

DATE OF INTERVIEW
(enter day and month)

DAY		MONTH	

PROVINCE
(tick [3] appropriate box)

GITEGA	
MWARO	
MURAMVYA	

COMMUNE NAME

HOUSEHOLD SAMPLE NUMBER

NUMBER OF VISITS BEFORE INTERVIEW WAS POSSIBLE
(circle [✓] the correct number)

1 2 3

GENERAL INFORMATION

How many members are there in your household? Please include all those sleeping in the dwelling for at least three of the last 12 months (May 2001 – May 2002), including children, adult relatives and domestic servants for whom you have financial responsibility.

NUMBER OF HOUSEHOLD MEMBERS
(including the main respondent)

HOW MANY OF THESE ARE ADULTS OVER THE AGE OF 18?
(enter the correct numbers. Include the main respondent)

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INTRODUCTION

PLEASE READ THE FOLLOWING TO THE RESPONDENT:

My name is _ _ _ _ _ _ _ _ _ _ _ _ _ _ _.

We are conducting a survey on a range of health care issues for The Ministry of Health in Burundi. In particular we would like to find out how much money households are contributing towards health care and the impact that this has on the household budget. We are also interested in other issues that affect the households ability to access health care services (e.g. time and travel costs) and would like to ask about your views on the current and future health services in your area. It is anticipated that the results from this survey will provide with important information that can be used to help improve the quality and fairness of health care services provided in this country.

In order to ensure that we obtain the views of a wide range of people we are surveying 1588 households in three provinces of the country. We have chosen households at random. We had no prior information about your household before calling on you today.

We can assure you that your responses will remain completely confidential. It will not be possible to identify yourself or your household in any way from the data analysis and reporting. Your responses to the questionnaire will not be disclosed, and once all the results have been compiled, they will only be used in a summary way.

We expect that this interview will take approximately 1 ½ hours to complete.

- Are there any questions that you would like to ask before we start?
- If you have any questions or difficulty understanding anything during the survey please ask and we will help.
- If you have any further questions about they survey after we have left, please contact us using the information indicated on this visit card.

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SECTION A: HOUSEHOLD MEMBER CHARACTERISTICS [ ][ ][ ][ ][ ]

Please could you first identify each member of the household, allocate them to one of the household member numbers below, then ask the following questions, ensuring that you obtain responses for every household member. In each case circle [✓] the correct number unless otherwise stated. If there are more than 8 people in the household then use the continuation sheet provided.

		Household Member ☺							
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
A1	***What is the relationship between each household member and the main respondent (household member ☺1)?***	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
		2	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	1. Main Respondent	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*
	2. Wife / Husband / Partner (cohabitation without official marriage) of Respondent	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*
	3. Son / Daughter of the main Respondent **AND** the Wife / Husband / Partner	*5*	*5*	*5*	*5*	*5*	*5*	*5*	*5*
	4. Son / Daughter of the main Respondent **OR** only the Wife / Husband / Partner	*6*	*6*	*6*	*6*	*6*	*6*	*6*	*6*
	5. Mother / Father of the main Respondent or of the Wife / Husband / Partner	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*
	6. Sister / Brother of the main Respondent or the Wife / Husband / Partner	*8*	*8*	*8*	*8*	*8*	*8*	*8*	*8*
	7. Grandson / Granddaughter of the main Respondent / Wife / Husband / Partner	*9*	*9*	*9*	*9*	*9*	*9*	*9*	*9*
	8. Grandmother / Grandfather of the main Respondent / Wife / Husband / Partner	*10*	*10*	*10*	*10*	*10*	*10*	*10*	*10*
	9. Other Relative								
	10. Non- relative household member								
A2	***What is their gender?***	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
		2	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	1. Male								
	2. Female								
A3	***How old is each member of the household?***								
	(Go through each person in turn and fill in their age in years making sure <u>all</u> three boxes are filled in e.g. if a person is 35 years old, put 035 in the boxes provided. If a child is less then 1 year old, put 001 in the boxes. If the age is not known or disclosed, put 999 in the boxes).								
A4	***What would you consider to be the migration status of each member of the household?***	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
		2	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	1. Permanent resident	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*
	2. Visitor	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*
	3. Displaced (i.e. previously from elsewhere in Burundi)	*999*	*999*	*999*	*999*	*999*	*999*	*999*	*999*
	4. Refugee								
	999. Don't know / Refuses to answer								

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No	Question	Household Member ☺1	☺2	☺3	☺4	☺5	☺6	☺7	☺8
A5	***What is the highest education level achieved by each member of the household?*** (If any members of the household are currently in full or part-time education, record what stage of their education they are at). 1. No education **AND NOT** pre-school 2. Pre-school 3. Primary school 4. Secondary school 5. Tertiary education 6. Crafts (technical / professional) 7. Missionary teaching 8. Other (e.g. unfinished primary school) 999. Don't know / Refuses to answer	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*
A6	***What is the marital status of each member of the household?*** (if the household member is under 18 years old circle 0) 1. Single 2. Married 3. Divorced / Separated 4. Widowed 999. Don't know / Refuses to answer	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*	*0* *1* *2* *3* *4* *999*
A7	***What is the employment status of each member of the household?*** (If a member of the household is a pre-school child, please fill in 0) 1. Works all year 2. Employed seasonally 3. Employed occasionally (i.e. not dependent on the season) 4. Other 5. Unemployed (no work in the last 12 months) } 6. No capacity to work (e.g. disabled) } *IF RESPOND* 7. Pupil or Student } *0,5,6,7,8,999* 8. Retired } *SKIP TO* 999. Don't know / Refuses to answer } *SECTION B*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*

No	Question	Household Member ☺1	☺2	☺3	☺4	☺5	☺6	☺7	☺8
A8	**What is the occupation of each household member?** (Each household member can have more than one occupation, circle as many numbers as you need to).	1	1	1	1	1	1	1	1
		2	2	2	2	2	2	2	2
		3	3	3	3	3	3	3	3
	1. Agricultural, own land/family land	4	4	4	4	4	4	4	4
	2. Agricultural, rented land	5	5	5	5	5	5	5	5
	3. Agricultural, any land	6	6	6	6	6	6	6	6
	4. Professional, technical, manager	7	7	7	7	7	7	7	7
	5. Civil service	8	8	8	8	8	8	8	8
	6. Sales, services	9	9	9	9	9	9	9	9
	7. Skilled manual	10	10	10	10	10	10	10	10
	8. Handicrafts	11	11	11	11	11	11	11	11
	9. Household and domestic	999	999	999	999	999	999	999	999
	10. Fishing								
	11. Other								
	999. Don't know / Refuses to answer								
A9	**For their <u>main</u> occupation (or main daily function), what is the main form of earnings for each member of the household?**	1	1	1	1	1	1	1	1
		2	2	2	2	2	2	2	2
	1. Earns cash	999	999	999	999	999	999	999	999
	2. Other								
	999. Don't know / Refuses to answer								

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SECTION B: HOUSEHOLD ILLNESS AND EXEMPTIONS [ ][ ][ ][ ][ ]

This section is about household illness and exemptions from paying parts of, or full health care costs. Ask the following questions, ensuring that you obtain responses for every household member. In each case circle [✓] the correct number unless otherwise stated.

			Household Member ☺							
	No	**Question**	**☺1**	**☺2**	**☺3**	**☺4**	**☺5**	**☺6**	**☺7**	**☺8**
	B1	**Please could you indicate whether any household members have any long-standing illnesses?** (Long-standing includes anything that has troubled them over a period of time, or that is likely to affect them over a period of time for example about 1 year). 1. Yes 2. No } *IF RESPOND 2, 999* 999. Don't know / Refuses to answer } *SKIP TO QUESTION No. B3.*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*
	B2	***Could you please indicate the nature of the most significant of these long-standing illnesses for each household member?*** ***(If the respondent has difficulty answering this question, read out the categories below. You must decide which illness is the most significant).*** 1. HIV / Aids 2. Heart problems 3. Diseases of the digestive-system 4. Respiratory diseases 5. Anaemia 6. TB 7. Diabetes 8. Malaria 9. Other 999. Don't know / Refuses to answer	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*
	B3	***Please could you indicate, for each member of the household, how they feel their general heath has been over the past month.*** *(Ask the respondent how happy or sad they feel about their health status over the last month and tick the appropriate box).*	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]	☺☺[ ] ☺ [ ] 😐 [ ] ☹ [ ] ☹☹[ ]

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		Household Member ☺							
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
B4	**Does the household member own an insurance card against illness that allows them a discount on health services? (Which type?)** 1. Carte d'assurance Maladie } IF RESPOND 2. Carte de la Mutuelle } 1,2,3 SKIP TO 3. Bon de soins (NGO, Bank) } QUESTION No. B6 4. None 999. Don't know / Refuses to answer } IF RESPOND 999 SKIP TO QUESTION No. B8.	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*
B5	**What is the household members reason for not owning a card?** (If the household member is under 18 or a student, circle 0. Circle one number only and SKIP TO QUESTION NO. B8.) 1. Didn't know it existed 2. Couldn't afford to buy one 3. Not yet bought one yet but intend to soon 4. Not required 5. Don't need because receive free services anyway (e.g. by missionaries) 6. Not needed because never sick/ill 7. Was not available when I wanted to buy it. 8. Do not find it useful. 999. Don't know / Refuses to answer	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *999*
B6	**Over the past 6 months, in which months has the household member used their card when obtaining health services?** (circle as many numbers as you need to, if none, circle 0) 1. December } 2. January } IF RESPOND 3. February } 1,2,3,4,5,6 4. March } SKIP TO 5. April } QUESTION NO. B8 6. May } 999. Don't know / Refuses to answer	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*	*0* *1* *2* *3* *4* *5* *6* *999*

			Household Member ☺							
No	*Question*		*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
B7	**Why has the household member not used their card in the last 6 months?**		*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
	1. Has not been ill/sick		*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	2. Have not sought any health services		*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*
	3. Receive free health services anyway		*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*
	4. Received treatment elsewhere where card not accepted		*999*	*999*	*999*	*999*	*999*	*999*	*999*	*999*
	999. Don't know / Refuses to answer									
B8	**Is the household member aware of an exemption system whereby certain people are exempt from paying for all or some health care services?**		*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
	1. Yes		*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	2. No	} IF NO, 999	*999*	*999*	*999*	*999*	*999*	*999*	*999*	*999*
	999. Don't know / Refuses to answer	} SKIP TO SECTION C								
B9	**Does the household member qualify for exemption of paying for all or some of the healthcare services they receive?**		*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
	1. Yes		*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	2. No	} IF RESPOND 2,999	*999*	*999*	*999*	*999*	*999*	*999*	*999*	*999*
	999. Don't know / Refuses to answer	} SKIP TO SECTION C								
B10	**Does the household member have an exemption document that proves that they are exempt from paying for all or some health care services?**		*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
	1. Yes		*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*
	2. No		*999*	*999*	*999*	*999*	*999*	*999*	*999*	*999*
	999. Don't know / Refuses to answer									

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			Household Member ☺						
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
B11	**Does the household member know what criteria are used to determine whether somebody is entitled to exemption from payment for all or some health care services?** (In the absence of an epidemic). 0. No 1. Children 2. Elderly 3. Poor (indigents) 4. Invalid 5. War widow 6. Refugee 7. A person suffering from mental health problems 8. Health care workers 9. Commune or Province workers 10. Friends of Commune or Province worker 999. Refuses to answer	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*	*0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *999*
B12	**Please indicate which category of exclusion they fall within.** (can circle more than one number) 1. Child 2. Elderly 3. Poor (indigents) 4. Invalid 5. War widow 6. Refugee 7. A person suffering form mental health problems 999. Don't know / Refuses to answer	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*

		Household Member ☺							
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
B13	**Does the household member know who determines whether somebody is entitled to exemption from payment for all or some health care services?** 1. No 2. Commune administrator 3. Province governor 4. Health care worker 5. Another commune / province worker 999. Don't know / Refuses to answer	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*
B14	**When receiving health care do they <u>always</u> get the exemptions that they are entitled to?** 1. Yes 2. No 999. Don't know / Refuses to answer	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*

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SECTION C: UTILISATION OF HEALTH CARE SERVICES [ ][ ][ ][ ][ ]

This section is about household utilisation of health care services. Ask the following questions, ensuring that you obtain responses for every household member. For some questions regarding recent illness and details of recent health care visits, it may be more appropriate for the parent of a child to respond on behalf of a child who is either too young or cannot remember. In each case circle [✓] the correct number unless otherwise stated.

		Household Member ☺							
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
C1	**In the last <u>month</u> has any household member suffered from any illness or injury or made a routine visit to a health facility or sought health advice?** 1. Yes } IF YES SKIP TO QUESTION No. C3 2. No 999. Don't know / Refuses to answer	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*
C2	**When was the last time (in the last 12 months) the household member suffered from any illness or injury or made a routine visit to a health facility or sought health advice?** 1. Sowing time ((January/February/March)d 2. Easter (April) 3. Harvest time (May/June) 4. Dry season (June/July/August/September) 5. Christmas (December) 6. Other (October/November) 7. None } IF RESPOND 7, 999 999. Don't know / Refuses to answer } SKIP TO SECTION D.	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*	*1* *2* *3* *4* *5* *6* *7* *999*
C3	**How is the household member now?** 1. Still unwell 2. Fully recovered 3. Recovered but with disability 4. Other 999. Don't know / Refuses to answer	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*	*1* *2* *3* *4* *999*

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		Household Member ☺							
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
C4	**What was the household members <u>most</u> recent illness / injury / reason for visit?** (Circle the number that most closely matches their response. If the respondent is reluctant to answer, read out the list of conditions below but make sure that they only give one response which relates most closely to the most recent illness / injury / visit). 1. Check-up: no illness or injury 2. Related to pregnancy / birth 3. Broken bones / trauma / injury 4. Eye problem 5. Teeth/ dental problem 6. Treatment for HIV/AIDS 7. Malaria 8. Other infectious disease 9. Cardiovascular disease 10. TB 11. Other respiratory problem 12. Diarrhoea related illnesses/diseases 13. Digestive problem 14. Mental health problem 15. Diabetes 16. Other 999. Don't know / Refused to answer	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *12* *13* *14* *15* *16* *999*
C5	**Overall, how many days the household member lose altogether from their normal activities (school/work/other) as a result of this recent illness?** (This should include all days spent prior to going to a facility to receive treatment/advice and all the days spent recovering from the illness). 0. Less than 1 day 1. 1 to 3 days 2. 4 to 7 days 3. 7 to 14 days 4. 15 to 28 days 5. Over 28 days 999. Don't know / Refuses to answer	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*	*0* *1* *2* *3* *4* *5* *999*

No	Question	Household Member ☺1	☺2	☺3	☺4	☺5	☺6	☺7	☺8
C6	**Did anyone else in the household have to take time out from their usual activities as a result of the household member's illness?**	1 [ ]	1 [ ]	1 [ ]	1 [ ]	1 [ ]	1 [ ]	1 [ ]	1 [ ]
	1. Yes } *INSERT THE NUMBER OF THE HOUSEHOLD MEMBER ☺ IN THE BOX*	2	2	2	2	2	2	2	2
	2. No								
	999. Don't know / Refuses to answer	999	999	999	999	999	999	999	999
C7	**For this most recent illness, did the household member seek health care advice/treatment from outside the home?**	1	1	1	1	1	1	1	1
	1. Yes } *IF YES, SKIP TO QUESTION No. C9*	2	2	2	2	2	2	2	2
	2. No	999	999	999	999	999	999	999	999
	999. Don't know / Refuses to answer								
C8	**Why did the household member not seek health advice or treatment from outside the household?**	1	1	1	1	1	1	1	1
	(Fill in their response then SKIP TO SECTION D).	2	2	2	2	2	2	2	2
	1. Sought health advice or treatment within the household	3	3	3	3	3	3	3	3
	2. Could not take time out of job	4	4	4	4	4	4	4	4
	3. Could not afford it at the time	5	5	5	5	5	5	5	5
	4. Too far to travel	6	6	6	6	6	6	6	6
	5. Don't like seeking advice or treatment	7	7	7	7	7	7	7	7
	6. Health workers are not well trained	8	8	8	8	8	8	8	8
	7. The health facilities are not well equipped	999	999	999	999	999	999	999	999
	8. Other								
	999. Don't know / Refuses to answer								
C9	**For this most recent illness, who did the household member seek advice or treatment from first (1st)?**	1	1	1	1	1	1	1	1
		2	2	2	2	2	2	2	2
	1. Private pharmacy / drug store	3	3	3	3	3	3	3	3
	2. Public health centre	4	4	4	4	4	4	4	4
	3. Private clinic	5	5	5	5	5	5	5	5
	4. Public hospital	6	6	6	6	6	6	6	6
	5. Private hospital	7	7	7	7	7	7	7	7
	6. Missionary health centre/hospital	8	8	8	8	8	8	8	8
	7. Traditional healer	999	999	999	999	999	999	999	999
	8. Mobile worker / facility								
	999. Don't know / Refuses to answer								

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		Household Member ☺							
No	*Question*	*☺1*	*☺2*	*☺3*	*☺4*	*☺5*	*☺6*	*☺7*	*☺8*
C10	**Did the household member seek any further health care advice/treatment from outside the home?** 1. Yes } *IF YES, GO TO QUESTION No. C12.* 2. No 999. Don't know / Refuses to answer	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*	*1* *2* *999*
C11	**Why did the household member not seek any further health advice or treatment from outside the household?** ***(Fill in their response then GO TO QUESTION No C16 and mark responses for the person/facility they went to 1st)*** 1. Sought health advice or treatment within the household 2. Could not take time out of job 3. Could not afford it at the time 4. Too far to travel 5. Don't like seeking advice or treatment 6. Health workers are not well trained / Health facilities are not well equipped 7. Not necessary 8. Other 999. Don't know / Refuses to answer	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*
C12	**For this most recent illness, who did the household member seek advice or treatment from second (2nd)?** 1. Private pharmacy / drug store 2. Public health centre 3. Private clinic 4. Public hospital 5. Private hospital 6. Missionary health centre/hospital 7. Traditional healer 8. Mobile worker / facility 999. Don't know / Refuses to answer	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *999*

No	Question	Household Member ☺1	☺2	☺3	☺4	☺5	☺6	☺7	☺8
C13	**Did the household member seek any further health care advice/treatment from outside the home?** 1. Yes } GO TO QUESTION No. C15. 2. No 999. Don't know / Refuses to answer	1 2 999	1 2 999	1 2 999	1 2 999	1 2 999	1 2 999	1 2 999	1 2 999
C14	**Why did the household member not seek any further health advice or treatment from outside the household?** ***(Fill in their response then GO TO QUESTION No C16 and mark responses for the person/facility they went to 1st and 2nd)*** 1. Sought health advice or treatment within the household 2. Could not take time out of job 3. Could not afford it at the time 4. Too far to travel 5. Don't like seeking advice or treatment 6. Health workers are not well trained / Health facilities are not well equipped 7. Other 8. Not necessary 999. Don't know / Refuses to answer	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999
C15	**For this most recent illness, who did the household member seek advice or treatment from third (3rd)?** 1. Private pharmacy / drug store 2. Public health centre 3. Private clinic 4. Public hospital 5. Private hospital 6. Missionary health centre/hospital 7. Traditional healer 8. Mobile worker / facility 999. Don't know / Refuses to answer	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999	1 2 3 4 5 6 7 8 999

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Questions No. C16 – C32. For each member of the household who sought health advice / treatment form outside the household, answer the following questions, circling (μ) the correct number for each person / facility they visited. Only mark the responses for the people / facilities they visited, if they did not visit a 2nd or 3rd person / facility leave these columns blank.

		Household Member ☺																							
		Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			***☺2***			***☺3***			***☺4***			***☺5***			***☺6***			***☺7***			***☺8***		
No	***Question***	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*	*1st*	*2nd*	*3rd*
C16	**On the day, how long did it take the household member to get to the person/facility?** 1. Less than 30 minutes 2. 30 minutes to 1 hour 3. 1 to 2 hours 4. Over 2 hours 5. 1 day or more 999. Don't know / Refuses to Answer	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*	*1* *2* *3* *4* *5* *999*
C17	**What type of transport did the household member use?** 1. Walk 2. Bicycle 3. Motorcycle 4. Car 5. Taxi (car) 6. Bus 7. Ambulance 8. Inderuzo 9. Other 999. Don't know / Refuses to Answer	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C18	**What was the cost of the transport?** *(Fill in the amount in BIF. Fill blank boxes with 0 e.g. BIF 23000 = [0][2][3][0][0][0]. If they used a car ask how many KM it was to the person/facility).*	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]	[ ][ ][ ][ ][ ][ ]
C19	**Was the household member accompanied by any other household member to the facility?** *(Enter the number of other household members or 0 if they were not accompanied).*	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ]
C20	**Who decided that the household member should seek health care/referred them for health care?** 1. Self 2. Another household member 3. Person / facility previously visited 4. Other 999. Don't know / Refuses to answer	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999	1 2 3 4 999

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C21	**How long did the household member have to wait between deciding to seek health care/being referred and a date to attend this facility?** 1. Less than a day 2. 2 to 4 days 3. 5 to 7 days 4. 8 to 14 days 5. 15 to 28 days 6. Over 28 days 999. Don't know / Refuses to answer	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999	1 2 3 4 5 6 999
C22	**Once you arrived on the day, how long did the household member have to wait until they saw the person that need to?** 1. Less than 30 minutes 2. 30 minutes to 1 hour 3. 1 to 2 hours 4. 2 to 4 hours 5. Over 4 hours 999. Don't know / Refuses to answer	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999	1 2 3 4 5 999

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																								
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C23	**What was the main reason for the visit?** (Circle as many as appropriate) 1. Check-up/advice 2. Examinations/Tests 3. Get medicines 4. Surgical care 5. Emergency procedure 6. Other 999. Don't know / Refuses to answer	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
		3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
		4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
		5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
		6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
		999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999
C24	**What was the total length of the visit.** (The total amount of time you were required to be with the person/at the facility). 1. Less than 5 minutes 2. 5 to 10 minutes 3. 10 to 30 minutes 4. 30 minutes to 1 hour 5. 1 to 2 hours 6. 2 to 4 hours 7. Over half a day 8. Overnight 9. 2 to 4 nights 10. 4 to 7 nights 11. 7 to 14 nights 12. Over 14 nights 999. Don't know / Refuses to answer	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
		3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
		4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
		5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
		6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
		7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
		8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
		9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
		10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
		11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11
		12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
		999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C25	**How much did the household member spend in total during this visit?** *(Include the costs of drugs, consultation fees, the costs of any tests, and any hospitalisation costs. Fill in the exact amount in BIF in the boxes provided. Put a 0 in any empty boxes e.g. 23000 = [0][2][3][0][0][0]. If nothing was spent fill in 000000. If they can't remember ask for an approximate figure. If they feel unable to do this or really don't know how much was spent, fill in 999999).*	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]
C26	**Do you know how much of the total amount (in C25) was spent on drugs?** *(Fill in the exact amount in BIF in the boxes provided. Put a 0 in any empty boxes e.g. 23000 = [0][2][3][0][0][0]. If nothing was spent fill in 000000. If they can't remember ask for an approximate figure. If they feel unable to do this or really don't know how much was spent, fill in 999999).*	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C27	**Do you know how much of the total amount (in C25) was spent on tests?** *(Fill in the responses in the same way as Question No. C26)*	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]
C28	**How much was spent overall on food during the visit?** *(Fill in the responses in the same way as Question No. C26)*	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]
C29	**How much was spent overall on payments to health care workers during this visit?** *(Include consultation fees, tips, and gifts. Fill in the responses in the same way as Question No. C26)*	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]

PLEASE TURN TO THE NEXT PAGE

No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C30	**Do you still owe any money for the visit?** *(Fill in the response in the same way as Question C26. Enter 000000 if they owe nothing)*	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]	BIF [ ][ ][ ][ ][ ][ ]
C31	**Where did the household member get the money from to pay for these costs?** (Circle as many responses as you need to). 1. Worked longer hours 2. Reduced expenditure on food 3. Reduced expenditure on fuel 4. Reduced expenditure on non-essential items 5. Household savings 6. Sold personal belongings 7. Sold household assets 8. Borrowed from another household member 9. Borrowed from a friend 10. Borrowed from a money lender (formal) 11. Borrowed from a money lender (informal) 12. Other 999. Don't know / Refuses to answer	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999	1 2 3 4 5 6 7 8 9 10 11 12 999

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No	Question	Household Member ☺ — Person / Facility Visited 1st, 2nd, 3rd.																							
		☺1			☺2			☺3			☺4			☺5			☺6			☺7			☺8		
		1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
C32	**How did the household member find the level of quality of the health care facility?** *(Read the possible responses to the household member. If they answer yes, circle the appropriate number.).* 1. The household member was treated well. 2. The medicine's needed/prescribed were all available. 3. The equipment was appropriate and available 4. The doctor was available/attentive. 5. The nurse was available/attentive. 6. The receptionist was available/attentive. 7. The state/structure of the health facility was good.	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7	1 2 3 4 5 6 7

SECTION D: HOUSEHOLD CHARACTERISTICS [ ][ ][ ][ ][ ]

PLEASE READ THE FOLLOWING TO THE INTERVIEWEE:

The set of questions we have just been through were about individual members of your household. We are now going to ask some questions about your household as a whole. We would therefore be very grateful if you could answer these last sections of the survey from the perspective of the household where possible, and from your own perspective only where this is impossible.

Please enter the amounts in boxes where appropriate or circle (✓) the correct number.

No.	*Question*	
	HOUSEHOLD INCOME	
D1	***Can you indicate the total monetary income (salaries and other income) that entered the household in the past month, taking into account every member of the household?*** (Try to get an exact amount. If they find this too difficult ask them to make an approximation. Fill in the total amount in the boxes putting a 0 into any empty boxes, e.g. BIF 23000 = [0][2][3][0][0][0]. If there is no income enter 000000. If they are unsure or are uncomfortable about giving an answer enter 999999).	BIF[ ][ ][ ][ ][ ][ ]
D2	***How does the household income last month compare with other time of the year?*** *1. It is the same all year round* *2. Less* *3. More* *999. Don't know / Refuses to answer*	*1* *2* *3* *999*
D3	***How much money do you receive per month from family members who live outside of the household?*** (If it is too difficult for the respondent to state an exact amount, ask for an approximate figure. Follow the instructions for filling in the amount from Question D1).	BIF[ ][ ][ ][ ][ ][ ]
	CONSUMPTION INDICATORS	
D4	***Please can you indicate how much in total the household spent on housing costs in the last month?*** (If it is too difficult for the respondent to state an exact amount, ask for an approximate figure. Follow the instructions for filling in the amount from Question D1).	BIF[ ][ ][ ][ ][ ][ ]
D5	***Please can you indicate how much in total the household spent on food in the last month?*** (If possible this should include any expenditure on food made outside the household environment. Follow the instructions for filling in the amount from Question D1)	BIF[ ][ ][ ][ ][ ][ ]
D6	***Please can you indicate how much in total the household spent on fuel (for cooking) in the last month? (e.g. gas, coal, wood).*** (Follow the instructions for filling in the amount from Question D1).	BIF[ ][ ][ ][ ][ ][ ]
D7	***Please can you indicate how much in total the household spent on support to relatives outside of the household in the last month?*** (If non-monetary support has been made in the form of gifts such as food, ask the respondent to estimate a monetary amount for these gifts. Follow the instructions for filling in the amount from Question D1)	BIF[ ][ ][ ][ ][ ][ ]
D8	***Please can you indicate how much in total the household spent on medicines and drugs in the last month?*** (Include the expenditure of every household member. Follow the instructions for filling in the amount from Question D1)	BIF[ ][ ][ ][ ][ ][ ]
D9	***Please can you indicate how much in total the household directly related to a hospital admission in the last month?*** (Include the expenditure of every household member. Follow the instructions for filling in the amount from Question D1)	BIF[ ][ ][ ][ ][ ][ ]

D10	***Please can you indicate how much in total the household directly related to other health care services in the last month?*** (Include the expenditure of every household member. Follow the instructions for filling in the amount from Question D1)	BIF[ ][ ][ ][ ][ ][ ]
D11	***Please can you indicate how much in total the household directly related to education in the last trimester or year?*** (Follow the instructions for filling in the amount from Question D1. Tick the appropriate box)	BIF[ ][ ][ ][ ][ ][ ] Trimester [ ] Year [ ]
D12	***Please can you indicate how much in total the household spent on paying back loans in the last month?*** (Include the expenditure of every household member and formal and informal loans. Follow the instructions for filling in the amount from Question D1)	BIF[ ][ ][ ][ ][ ][ ]
D13	***Please can you indicate how much money in total the household has saved / put aside in the past month.*** (Include the total savings of every household member and all informal and formal savings schemes and plans. Follow the instructions for filling in the amount from Question D1).	BIF[ ][ ][ ][ ][ ][ ]
D14	***Overall, how would you assess the financial situation of your household as a whole over the past month as compared with the rest of the year?*** *1. Poorer than average* *2. Better off than average* *3. Same* *999. Don't know / Refuses to answer*	*1* *2* *3* *999*
D15	***How do you feel the household compares financially with other households in your commune?*** *1. Much poorer than average* *2. Little poorer than average* *3. About average* *4. Little better off than average* *5. Much better off than average* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *999*
D16	***Does the household owe any money to anyone else at the moment?*** (If no, circle 0) *1. Friend* *2. Relative* *3. Formal money lender* *4. Informal money lender* *5. Other* *999. Don't know / Refuses to answer*	*0* *1* *2* *3* *4* *5* *999*

	HOUSEHOLD ASSETS	*YES*	*NO*	*QUANTITY*
D17	***Does the household (or does an individual member of the household) own a radio?*** (Please tick [✓] the correct box and if yes, enter the quantity).			
D18	***Does the household (or does an individual member of the household) own a television?*** (Please tick [✓] the correct box and if yes, enter the quantity).			
D19	***Does the household (or does an individual member of the household) own a telephone?*** (Please tick [✓] the correct box and if yes, enter the quantity).			
D20	***Does the household (or does an individual member of the household) own a refrigerator?*** (Please tick [✓] the correct box and if yes, enter the quantity).			
D21	***Does the household (or does an individual member of the household) own a bicycle?*** (Please tick [✓] the correct box and if yes, enter the quantity).			

SECTION D: HOUSEHOLD CHARACTERISTICS [ ][ ][ ][ ][ ]

No	Question		YES	NO	QUANTITY
D22	**Does the household (or does an individual member of the household) own a motorcycle?** (Please tick [✓] the correct box and if yes, enter the quantity).				
D23	**Does the household (or does an individual member of the household) own a private car?** (Please tick [✓] the correct box and if yes, enter the quantity).				
D24	**Does the household (or does an individual member of the household) own any animals?** (Please tick [✓] the correct box and if yes, enter the quantity).	*Cows*			
		Sheep			
		Goats			
		Chickens			
		Pigs			
D25	**Does the household (or does an individual member of the household) own any land?** (Please tick [✓] the correct box and if yes, enter the quantity) (area)).	*Grazing*			
		Crop Growing			
		Other			
	HOUSING CHARACTERISTICS				
D26	**Does the house have electricity?** 1. *Yes* 2. *No* 999. *Don't know / Refused to answer*				*1* *2* *999*
D27	**What is the drinking water source for the house?** 1. *Piped water* 2. *Well water* 3. *Surface water* 4. *Rainwater* 5. *Tanker truck* 6. *Bottled water* 7. *Other* 999. *Don't know / Refused to answer*				*1* *2* *3* *4* *5* *6* *7* *999*
D28	**How long does it take to reach the drinking water supply?** (Insert the number of minutes it takes to reach a fresh drinking water supply from the household).				*[ ] [ ] [ ]* (Mins)
D29	**What type of toilet/latrine facility does the house have?** 1. *Flush toilet/latrine* 2. *Pit toilet/latrine* 3. *No facility* 4. *Other* 999. *Don't know / Refused to answer*				*1* *2* *3* *4* *999*
D30	**How many rooms are there in the house?**				*[ ] [ ]* (Rooms)
D31	**How many people sleep in a room?**				*[ ] [ ]* (People)
D32	**What is the approximate distance, in KM, from the household to the nearest Pharmacy?**				*[ ] [ ]* (KM)
D33	**What is the approximate distance, in KM, from the household to the nearest Health Centre/Clinic?**				*[ ] [ ]* (KM)
D34	**What is the approximate distance, in KM, from the household to the nearest Hospital?**				*[ ] [ ]* (KM)

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SECTION E: HOUSEHOLD PERCEPTIONS [ ][ ][ ][ ][ ]

In this final section, we would like to ask you some questions to obtain the views of this household on the health care services of Burundi and how these could be developed in the future. We are also interested in how the household makes decisions regarding seeking health care. It will be useful for us if you can answer these questions on behalf of your household (where appropriate) even if no health care services have been used.

Please circle (✓) the correct number.

No.	*Question*	
	CURRENT SERVICE	
E1	***What does the household think about the overall quality of the health care services provided in their commune?*** *1. Very good* *2. Good* *3. Satisfactory* *4. Poor* *5. Very poor* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *999*
	FUTURE SERVICE	
E2	***Do you think that the Government of Burundi should provide free health care?*** (Read out options 1 to 4 to the household member). *1. Yes, for all individuals* *2. Yes, but only for people who cannot pay for their own health care* *3. Yes, for all those who cannot pay for themselves and other specified individuals* *4. Just reduce the price of drugs/medicines* *5. No* *6. Other* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *6* *999*
E3	***Do you think more money, less money, or the same amount of money should be spent on health care in Burundi?*** *(Read the options to the household member).* *1. Much more* *2. More* *3. Same amount* } IF RESPOND *4. Less* } 3,4,5,999 *5. Much less* } SKIP TO QUESTION *999. Don't know / Refuses to answer* } No.E5	*1* *2* *3* *4* *5* *999*
E4	***Where should the additional funding some from? What about the following options?*** *(Read the options to the household member).* *1. From other Government departments* *2. Raising money through taxes* *3. Getting patients to pay more for using the service* *4. A mixture of the above* *5. Other* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *999*

No.	Question	
E5	***Do you think some people should receive more funding or better health care services than others? (Which people?)*** *(Circle as many types of people as necessary).* *1. Rich people* *2. Poor people* *3. Children* *4. The elderly* *5. Disabled people* *6. Health care workers* *7. Widow(er)s* *8. Refugees / Displaced people* *9. People injured through war* *10. People with certain diseases (e.g. HIV, Diabetes)* *11. Nobody* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *11* *999*
E6	***If you have to pay for health care services, which of the following options would you prefer?*** *(Read the options to the household member).* *1. Pay a charge covering the full cost at the point of use for seeing a health care worker* *2. Pay a fixed amount each month, and when you need to seek health care, pay nothing* *3. Pay a smaller amount each month, and when you need to health care pay a % of the costs of care/treatment* *4. Another option } Explain _____* *5. Not pay at all* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *999*
E7	***What one thing could be done to improve the heath facility nearest to you?*** *1. The member could be treated well/better.* *2. The medicine's needed/prescribed should all be available.* *3. The equipment should be appropriate and available* *4. The doctor should be available/attentive.* *5. The nurse should available/attentive.* *6. The receptionist should available/attentive.* *7. The state/structure of the health facility should be better.* *8. Provision of patient transport to and from the health* *9. Other } Explain _____* *999. Don't know / Refuses to answer*	*1* *2* *3* *4* *5* *6* *7* *8* *9* *999*

	QUALITY IMPROVEMENTS		
	Would you be willing to pay for … ? **(Tick [3] appropriate box)**	*YES*	*NO*
E8	*Better staff attitudes*		
E9	*Better provision and range of drugs*		
E10	*Better quality equipment*		
E11	*A highly qualified and devoted Doctor*		
E12	*A well qualified and devoted nurse*		
E13	*A well motivated and pleasant receptionist*		
E14	*Patient transport to and from the health facility*		
E15	*Other (Explain) _____*		

No.	*Question*	
	INTRA-HOUSEHOLD DECISION-MAKING	
E16	***If a child from within the household were ill, who would decide whether to seek health care advice/treatment from outside the household?*** (Enter household member number. Can enter more than one number if it a joint decision).	*[ ] [ ]*
E17	***Which member(s) of the household would accompany the child to the health care worker/facility?*** (Enter household member number. Can enter more than one number).	*[ ] [ ]*
E18	***If there were two people from within the household who were taken ill but there was only enough money for one of these people to seek health care advice/treatment outside of the household which household member(s) would decide who should be treated?*** (Enter household member number. Can enter more than one number if it a joint decision).	*[ ] [ ]*
E19	***How would this decision be made? Which would be the most important factors that you would take into consideration?*** (Read the list below to the household member(s) (in E18) and ask them to consider which they think is the most important criterion and which they think is the least important. Enter the corresponding numbers into the boxes opposite) *1. Male* *2. Female* *3. Worker* *4. Child* *5. Family member* *6. The nature of the disease/illness* *7. The severity/urgency of the disease /illness* *8. Choose at random*	*Most important* *[ ]* *Least important* *[ ]*

PLEASE READ THE FOLLOWING TO THE INTERVIEWEE:

Thank you very much for your time and patience today. We are very grateful for your involvement in this survey. If there is anything else you would like to discuss please contact us and someone may be able to help you. Once again, thank you and goodbye.

NOW REMEMBER TO FILL IN THE BASE INFORMATION ON THE FRONT SHEET OF THE QUESTIONNAIRE.

IX. ANNEX 5: Kirundi translation sheet for Household Survey.

No	Question
A1	Musana iki na nyen'Urugo N(Nyen'Urugo ☺1) ?
A2	Mbarira igitsina cawe ?
A3	Umaze imyaka ingahe ?
A4	Mbega muri abaha ?
A5	Mega mwize amashure angahe?
A6	Mbega murubatse ?
A7	Mbega murakora ?
A8	Mega mubeshejweho n-iki ?
A9	Mbega mu kazi ukora urahembwa ?

B1	Muri uru Rugo rwawe hariho umuntu yigeze asinzikara igihe kinini?
B2	Mbarira icatumye asinzikara cane ?
B3	Mbega mu kwezi guheze mu muryango mwari mumeze gute ?.
B4	Mega abantu bose baba muri uru Rugo barafise ikarata yo kwivurizako ituma batisahura mu kwivuza? (Ni iyihe?)
B5	Ni kuki ata karata ufise?
B6	Muri aya mezi 6 aheze ni ryari wigeze ukoresha iyo karata mu kwivuza?
B7	Marira igituma abantu bo muri uru rugo batigeze bakoresha ikarata yo kwivurizako?
B8	Mbega abantu bo muri uru Rugo boba bazi ko hari uburyo bwo kuronka imiti ku mahera make ? Ataco batatanze ?
B9	Mbega muri uru Rugo hari abantu bivuza kuri gusa ataco biriwe barasabwa ?
B10	Mbega muri uru Rugo hari umuntu yoba afise urupapuro rwerekana ko akwiye kwivuza kuri gusa ?
B11	Mbega muri uru Rugo hoba hariho umuntu yoba azi ibiranga uwo wese ategerezwa kwivuza kuri gusa ?
B12	Tubwire imirwi y-abantu bo muri urugo yoba idatanga amahera yo kwa muganga ?
B13	Mbega woba uzi uwujejwe abantu kugena abashobora kwivuza kuri gusa ?
B14	Iyo bagiye kwivuza kwa muganga ubwo abasanzwe bivuza ku buntu barubahirizwa ?

C1	Mu kwezi guheze hari umuntu wo muri uru Rugo yagwaye,canke yakomeretse canke yapfuye kuja kwa muganga aja kubaza uko amerewe ?
C2	Ni ryari umuntu wo muri uru Rugo aheruka : kugwara , gukomereka canke yoba yaragiye kwa muganga kubaza uko amerewe ?
C3	Ubu umerewe gute ?

C4	Ni iyihe ngwara iheruka gusinzikaza umuntu wo mur'uru rugo ?
C5	Muri rusangi wamaze igihe kingna iki ata co wimarira mu mirimo yawe ya minsi yose (kuja kw'ishure gukora,kwisumamwo) bitewe niyo ngwara yari yagufashe ?
C6	Mbega muri uru Rugo hariho umuntu yaciye aheba imirimo yiwe kubera kugwaza ?
C7	Mbega uwo mugwayi yoba yaragiye gusaba impanuro muganga/canke yoba yaragiye kwivurza ahandi ?
C8	Kubera iki uwo mugwayi atiriwe aja kwivuza canke ngo aje gusaba impanuro muganga ?
C9	Igihe yari ku musego ninde uwo mugwayi yituyeko ubwambere ?
C10	Hoba hari ahandi uwo mugwayi yoba yararoye kurondera imiti canke impanuro za muganga ?
C11	Ni kuki uwo mugwayi ata handi yiriwe araja kurondera imiti canke impanuro za muganga ?
C12	Igihe uwo mugwayi yari ku musego ninde yirukiye ubugira kabiri
C13	Mbega uwo mugwayi hari ahandi yoba yararoye kwivuza/kurondera impanuro za muganga ?
C14	N ik cabujije uwo mugwayi kuja kwivuza canke ngo asabe impanuro muganga ?
C15	Igihe uwo mugwayi yarafashwe n'iyo ngwara ninde yivujeko ubugira gatatu)?

C16	Igihe umugwayi yaragiye kwivuza yamaze umwanya ungana gute kugira ngo ashike kuwo yifuza?
C17	Wagiye n'iki kwivuza?
C18	Warishe amahera angahe mu gushikayo ?
C19	Hari u muntu wo mu nzu yaguherekeje igihe waja kwivuza ?
C20	Ninde yafshe ingingo yo kukurungika kwa munganga ubwa mbere ?
C21	Kuva ico gihe no kugira ushike aho wivuriza vyagutwaye umwanya ungana gute ?
C22	Warindiriye umwanya ungana gute kugira ubonane n'uwo wivuzako?
C23	Wabitumwe n'iki kuja kwivuza ?
C24	Mwamaranye umwanya ungana gute n'uwukuvura ?
C25	Vuga amahera yose watanze igihe wivuza ?
C26	Watanze amahera angana gute ku miti ?
C27	Watanze amahera angana gute kubipimo n'ibindi vyose bakugiriye ?
C28	Igihe waja kwivuza, ivyo wafunguye canke wanyoye vyagutwaye amahera angahe ?
C29	Watanze amahera angahe kugira ngo bagusuzume ?
C30	Hari uwo woba ufitiye amahera?
C31	Amahera umugwayi yakoresheje mu kwivuza yayakuye hehe ?
C32	Kwa muganga wasanze hifashe gute ?

D1	Wotubwira amahera yose umuryango washoboye kuronka mu kwezi guheze (imishahara,n'ayandi mahera waronse)utibagiye no gushiramwo n'intererano y'umuntu wese aba muri urwo rugo ?
D2	Ugereranije n'ibindi bihe ubona hari akarusho muri uko kwezi guheze ?
D3	Mwoba mufise umuntu aja arabasahiriza mu kubarungikira amahera?
D4	Inzu ubamwo wayirishe amahera angahe ukwezi guheze ?
D5	Wotubwira amahera wasumishije ukwezi guheze uko angana?
D6	Tubarire amahera wakoresheje mu kugura inkwi canke amakara mu kwezi guheze?
D7	Wotubwira amahera woba warafashishije incuti ukwezi guheze uko angana?
D8	Tubwire amahera waguze imiti mu kwezi guheze uko angana?
D9	Tubwire amahera watanze mu bitaro muri uku kwezi guheze ?
D10	Nta yandi mahera woba waratanze ajanye no kwivuza muri uku kwezi guheze ?
D11	Mu gice giheze c'umwaka watanze amahera y'ishure angahe?
D12	Woba wishuye amahera angahe mu kwezi guheze ?
D13	Waziganije amahera angahe mu kwezi guheze ?.
D14	Muri rusangi ubona ubutunzi bwifashe gute muri uku kwezi guheze ugereranije n'ayandi mezi ?
D15	Wigereranije n'abandi bo mw'ikomine iwanyu ubona ubutunzi bwawe bwifashe gute ?
D16	Hari umuntu mwoba mufitiye umwenda ubu ?
D17	Mbega mu muryango murafise iradiyo (canke umwe mubaba muri uwo muryango) ?
D18	Mbega mu muryango muratunze imbonesha-kure (canke umwe mubaba muri abo baba mu muryango) ?
D19	Mbega mu muryango muratunze telefone(canke umwe muri abo baba ngaho) ?
D20	Mbega mu muryango murafise icuma co gukanyisha ibintu(frigo) ?
D21	Mbega mu muryango muratunze ikinga (canke umwe mu baba munzu) ?
D22	Mbega mu muryango muratunze ipikipiki (canke umwe muabo baba ngaha) ?
D23	Mbega mu muryango murafise umuduga (canke umwe muri abo baba munzu) ?
D24	Mbega mu muryango muratunze ibitungwa (canke umwe muri abo baba ngaho) ?
D25	Mbega mu muryango murafise itongo (canke umwe muri abo baba rugo) ?
D26	Mbega iinzu yanyu irimwo umuyaga-nkuba ?
D27	Quel est le système d'alimentation en eau potable de votre maison ?
D28	Iyo mugiye kuvoma bigutwara umwanya ungana gute ?
D29	Mbega murafise akazu ka Surwumwe mu nzu ? Kameze gute ?
D30	Inzu yawe ifise ivyumba bingahe ?

D31	Mu cumba kimwe harara bangahe?
D32	Imangazini y`imiti ikwegereye iri ku birometero bingahe?
D33	Ivuriro rikwegereye riri ku birometero bingahe?
D34	Ibitaro bikwegereye biri ku birometero bingahe?

E1	Mwiyunvira iki ku kuntu amavuriro abafasha mw'ikomine yanyu ?
E2	Wibaza ko Leta y'Uburundi yoshobora kuvuza abantu ku buntu ?
E3	Wibaza ko amahera akoreshwa mu buvuzi mu Burundi akwiye ?
E4	Niyo yaba adakwiye wibaza ko amahera yo kongeza yova hehe ?
E5	Wibaza ko hari abakwiye kuvuzwa neza kuruta abandi ?Ni bande
E6	Wifuza ko woriha gute ugiye kwivuza ?(Musigurire)
E7	Hokorwa iki kugira ngo ivuriro ribegereye ribafashe kurusha ?
	Woshobora gufasha muri ibi muri ibi bikwikira ?
E8	Imigenzo myiza y'abakozi bo mu buvuzi
E9	Mu kugira ngo ibitaro bize biraronka ubwoko bwose bw'imiti iminsi yose
E10	Mu kugira ibitaro vyonse bironswe ivyuma bikomeye
E11	Mu kugira turonke abaganga benshi kandi bavyigiye bihebera abanyigihugu
E12	Mu kugira turonke abaforoma banonosoye ubuhinga bwo kuvura kandi bitanga mu kazi kabo
E13	Mu kugira ibitaro bironke abafasha b-abavuzi kandi bihebera abandi
E14	Mu kuronka uburyo bubereye bwo kwunguruza abawaye kwa muganga
E15	Ibindi (Bisigure) _____
E16	Umwana agwaye mu muryango ninde afata ingingo yo kuja kumuvuza ?
E17	Ninde yojana uwo mwana kwa muganga igihe agwaye ?
E18	Mu muryango harwaye abantu babiri hakaba hari uburyo bwo kuvuza umwe ninde azofata ingingo yo gutora uwuvuzwa ubwa mbere?
E19	Iyo ngingo imaze gufatwa hokwisungwa iki ?

X. ANNEX 6: Key informant questionnaire / interview guide

QUESTION GUIDE FOR KEY INFORMANT INTERVIEWS

Key Informants:	
Provincial Governor	• Health insurance • Exemption policy and practice • Perceptions of service provision
Commune administrator	• Health insurance • Exemption policy and practice • Perceptions of service provision
Head of local school (Primary & Secondary)	• Perceptions of service provision • Perceptions of household illness and treatment decisions
Traditional Birth Attendant	• Perceptions of service provision • Perceptions of household illness and treatment decisions
Religious Heads (Catholic & Protestant & Muslim)	• Perceptions of service provision • Perceptions of household illness and treatment decisions

Key Informant interviews

Data sheet

(Baseline)

Province	
Commune	
Zone	
Visit No.	
Date	

1. Insurance

1.1. How do people in this area obtain an insurance card that entitles them to a discount for health care services (e.g. carte d'assurance maladie, carte de la mutuelle, bon de soins)? What is the official procedure?

1.2. How much does it cost per month?

Type of Card	**Enter amount (BIF) per month or % (i.e. if taken as salary)**
Carte d'assurance maladie	
Carte de la mutuelle	
Bon de soins	

1.3. Are there any other local insurance schemes (against sickness) that exist (either formally or informally) that are not listed above (e.g. possibly between groups of farmers)? If so, can you explain what they are called and how they work).

1.4. What happens when somebody claims that they cannot afford to purchase an insurance card or pay into the insurance scheme?

1.5. Do you have an idea of how many cards are in circulation in your area (either Commune or Provincial level)?

Type of Card	**Enter Number**	**Commune/Province (enter c or p)**
Carte d'assurance maladie		
Carte de la mutuelle		
Bon de soins		

1.6. Is it easy to obtain an insurance card without actually paying for one?

1.7. How much money (BIF) is collected per month or year from the issuing of insurance cards at the Commune or Provincial level?

Type of Card	**Amount (BIF)**	**Per year or month (enter y or m)**	**Commune/Province (enter c or p)**
Carte d'assurance maladie			
Carte de la mutuelle			
Bon de soins			

1.8. What happens to this money: how is it recorded and what is it used for?

2. Exemption Policy and Practice

2.1. How do people in this area obtain exemption from paying for health care services? What is the official procedure?

2.2. What are they exempt from paying? What do they still have to make small contribution for? And how much is this contribution? (List)

2.3. Do you have an idea of how many households are exempt in your area (either Commune or Provincial level)?

Enter Number	% of households in area	Commune/Province (enter c or p)

2.4. How are the costs for those people that are exempt covered by the Commune or Province?

2.5. How do you assess who is eligible for exemption? What are the criteria that you use

2.6. Are these the same across Burundi?

2.7. How do you validate claims for exemption? Do you make checks of the exemption claims or ask that exemption is updated or renewed every so often in order to see how people's circumstances change?

2.8. What things do you think prevent people from obtaining official exemption status when they are actually entitled to it?

2.9. *(For some of the problems raised in previous question ask the following*). How could this difficulty be reduced or addressed so that more people who are entitled to exemption receive this exemption more easily?

Difficulty 1	
Difficulty 2	
Difficulty 3	

2.10 Do you think there are too many or too few people getting free treatment? Why?

3.0. Perceptions of service and Provision

3.1. How do you think the health services in your area compare with the rest of Burundi?

3.2. What do you see as being the main problems with the health services in your area? (List 3 problems for each type of facility)

	Health Facility		
Problem	**Pharmacy**	**Public Health Clinic**	**Public Hospital**
Problem 1			
Problem 2			
Problem 3			

3.3. How do you think these could be overcome?

	Health Facility		
Solution	**Pharmacy**	**Public Health Clinic**	**Public Hospital**
Solution 1			
Solution 2			
Solution 3			

3.4. List 1 thing that could be done to improve each type of facility in your area.

	Health Facility		
Improvement	**Pharmacy**	**Public Health Clinic**	**Public Hospital**
Improvement			

4.0 Perceptions of household illness and treatment decisions

4.1. What do think about the health of the children that live in this area? What are the main types of illnesses that affect them?

4.2. Do you carry out health checks at your school or church? What types of checks are these? (e.g. eye test, vaccinations)

4.3. Are you ever approached by families who ask for your help with health care costs or medicines?

4.4. If you can provide help, how do you do this? (i.e. what form of help do you offer: money or food etc.)

4.5. How do they think services could be better provided for families who claim they cannot afford health care or who's access is inhibited by the costs?

XI. ANNEX 7: Facility questionnaire / interview guide

FACILITY QUESTIONNAIRE

INTERVIEWS WITH HEALTH WORKERS		
Staff to be interviewed		Topics covered
Pharmacy	Pharmacist	• Illness & treatment • Charging and exemption practice • Utilisation and revenues
Traditional Healers / Practitioners	Healers / Practitioner	• Illness & treatment • Charging and exemption practice • Utilisation and revenues
Health centre - public - private - religious	Head of centre	• Charging and exemption practice • Utilisation and revenues
	Doctor / Nurse	• Illness & treatment • Charging and exemption practice
Hospitals - private - public - religious	Medical Director	• Charging and exemption practice • Utilisation and revenues
	Administrator	• Charging and exemption practice • Utilisation and revenues
	Doctor / Nurse	• Illness & treatment • Charging and exemption practice
	Pharmacy worker	• Charging and exemption practice

Facility-based interviews

Data sheet

(Baseline)

Facility		Date	
Interviewer Code		Informant	
Visit No.			

1. Illness and treatment

1.1. What are the main services provided by this facility?

2. Charging and exemption policy practice ***(traditional practitioners go Q.10)***

2.1. What are the different types of fee / charge that patients have to pay when they use this facility, and how much do they have to pay? **(With <u>and</u> without an insurance card that entitles them to a discount from health care services [e.g. carte d'assurance maladie, carte de la mutuelle, bon de soins]).**

	INSURED		**NOT INSURED**	
	YES	AMOUNT (BIF)	YES	AMOUNT (BIF)
Consultation fee (i.e. with doctor or pharmacist)		[ ][ ][ ][ ][ ][ ]		[ ][ ][ ][ ][ ][ ]
Drugs (i.e. whether the full costs of drugs is covered even in hospital)		[ ][ ][ ][ ][ ][ ]		[ ][ ][ ][ ][ ][ ]
Simple procedures		[ ][ ][ ][ ][ ][ ]		[ ][ ][ ][ ][ ][ ]
Testing / lab charges		[ ][ ][ ][ ][ ][ ]		[ ][ ][ ][ ][ ][ ]

2.2. Is it possible for people to obtain exemption for use at this facility? ***What do they have to do (the official procedure)?***

2.3. Is the use of insurance cards and claims for exemption recorded at this health facility?

2.4. *(Linking the question above)*. What is the utilisation rates for the various insurance cards and exemptions? Or if figures are not available do they have a rough idea of what proportion of patients using this facility have insurance cards or proof that they are exempt from full payment of health care services?

Type of Card or Exemption	**Enter %**
Carte d'assurance maladie	
Carte de la mutuelle	
Bon de soins	
Official Exemption	

2.5. What happens when a person claims that they are exempt but have no official proof?

2.6. What things do you think prevent people from obtaining official exemption status when they are actually entitled to it?

2.7. *(For some of the problems raised in previous question ask the following*). How could this difficulty be reduced or addressed so that more people who are entitled to exemption receive this exemption more easily?

Difficulty 1	
Difficulty 2	
Difficulty 3	

2.8. Do you think there are too many or too few people getting free treatment? Why?

2.9. What proportion of this facility's cash resources / or recurrent revenue is derived from user fee revenue?

2.10. If more people could get an exemption certificate, how would this affect this facility / pharmacy / drug supply?

For Traditional Practitioners Only

2.11. What services do you provide?

2.12. What are your prices? Do you vary these depending on the patient's circumstances?

2.13. Do you provide credit or accept alternative forms of payment?

Utilisation and Revenue Data

Year	1989/1990		1999/2000		2000/2001		2001/2002	
	OP	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**
Utilization								
Total Number of Free patients								
Value of free patient care (BIF)								
User fee revenue								

OP = Outpatient

IP = In-Patient

XII. ANNEX 8: Focus groups discussion guide (French)

LE GUIDE DU QUESTIONNAIRE POUR LES FOCUS GROUPE DES ADULTES (>18) (GROUPE DES HOMMES, GROUPE DES FEMMES) GITEGA, MWARO, MURAMVYA

SUJET 1. La maladie et le traitement

1. Quelles sont les principales maladies qui affectent le plus les adultes? (Différentier les maladies bénignes et graves).

2. Quelles sont les principales maladies qui affectent le plus les enfants? (Différentier les maladies bénignes et graves).

SUJET 2. Le comportement dans la recherche des soins de santé et la Prise de décision sur la santé.

1. Qu'est ce qui arriverait si quelqu'un dans ta famille (une personne adulte ou un enfant) était atteint d'une maladie bénigne (par exemple: tu peux prendre une maladie parmi la liste des maladies évoquées précédemment)

EXPLORE POUR:
- QUI EST CE QU'ILS CONSULTERONT EN PREMIER LIEU
- LES DIFFERENCES QUI POURRAIENT EXISTER AU SEIN DES FAMILLES ENTRE HOMMES ET FEMMES
- QUELLES SONT LES RAISONS AVANCEES POUR MOTIVER LES INITIATIVES PRISES
- ESSAYER DE DONNER DES EXEMPLES AUTHENTIQUES

2. Qu'est ce qui arriverait si l'état de cette personne(adulte)s'empirait?

EXPLORE POUR:
- QUI EST CE QU'ILS CONSULTERONT EN SECOND ET EN TROISIEME LIEU
- LES DIFFERENCES QUI PORRAIENT EXISTER AU SEIN DE LA FAMILLE ENTRE HOMMES ET FEMMES
- QUELLES SONT LES RAISONS AVANCEES POUR MOTIVER LES INITIATIVES PRISES
- ESSAYER DE DONNER DES EXEMPLES AUTHENTIQUES

3. Qu'est ce que tu ferais si une personne adulte dans ta famille était atteinte d'une maladie grave aiguë ou blessure (par exemple: tu peux prendre une maladie parmi la liste des maladies évoquées précédemment).

EXPLORE POUR:
- QUI EST CE QU'ILS CONSULTERONT ? LES DIFFERENCES QUI POURRAIENT EXISTER AU SEIN DES FAMILLES ENTRE HOMMES ET FEMMES
- QUELLES SONT LES RAISONS AVANCEES POUR MOTIVER LES INITIATIVES PRISES ? ESSAYER DE DONNER DES EXEMPLES AUTHENTIQUES

4. N'avez vous jamais eu à retarder le moment de te faire soigner (cad une attente prolongée entre le temps de la prise de décision et le moment de te faire soigner)?

EXPLORE POUR:
POURQUOI IL PEUT Y AVOIR UN RETARD DANS LA RECHERCHE DU TRAITEMENT ?

5. Quand un enfant tombe malade qui est ce qui prend la décision de ce que l'on doit faire /ou il faut s'adresser?

EXPLORE POUR:
QUI PREND LA DECISION SELON DIFFERENTS TYPES DE MALADIES ? SELON QU'IL Y A DES DISCUSSIONS PARMI LES MEMBRES DE LA FAMILLE ? SELON QUE LE CONSEIL A ETE CHERCHE EN DEHORS DE LA CELLULE FAMILIALE (QUI SONT CES GENS) ?

6. As-tu besoin de demander d'une permission pour aller chercher un traitement ?

SUJET 3. Les contraintes d'accès aux soins de santé

Dans la précédente présentation nous avons parlé des sujets ou certaines personnes doivent différer la date de leur traitement médicament. Maintenant nous voulons connaître un peu pourquoi on peut ne pas être en mesure d'avoir accès aux soins de santé ou d'utiliser les services de santé.

1. Pour accéder aux services de santé (càd de l'officine, centre de santé public, hôpital public), que pense tu être le plus grand problème pour les familles?

EXPLORE POUR:
- LES COUTS DU TRAITEMENT
- LA QUALITE DES SERVICES
- LA DISTANCE
- L' EXPERIENCE ANTERIEURE

2. A quelle période de l'année est-il difficile de payer les frais médicaux / le traitement pour les membres de famille malades ?

EXPLORE POUR:
QUAND ET POURQUOI ?

3. Quelle est la plus grande difficulté à laquelle les différents types de ménages font face dans le payement des soins de santé ? Quels sont les ménages qui ne connaissent pas ces problèmes?

4. Y a t il des périodes ou vous aviez souhaité chercher du traitement pour votre enfant mais que cela n'a pas été possible?

5. Lorsqu'un enfant tombe malade et que vous n'avez pas d'argent pour le faire soigner, alors qu'est ce qui se passe ?

EXPLORE POUR:
- TOUTES LES STRATEGIES ENVISAGEES (Ne pas chercher de traitement, Emprunter, Recevoir de cadeaux, Vendre des récoltes / ou des biens pour collecter de l'argent)
- LES RESEAUX DE SOLIDALITES SOCIALES ET L'ECHANGE ENTRE LES MENAGES
- L'ORDRE DANS LEQUEL CES ACTIONS DEVRAIENT SE SUIVRE(par ex... Vendriez vous vos biens en premier lieu ou bien faudrait-il emprunter d'abord)
- LES DIFFERENCES SELON QU'IL S'AGIT DES MALADIES BENIGNES ET GRAVES
- L' IMPLICATION CES STRATEGIES (par ex. Quelles sont les implications de la vente des biens sur les ménages ? et en particulier les implications de la dette et de l'emprunt par des moyens formels et informels sur les ménages)

SUJET 4. L'assurance et le système d'exemption

1. Combien de types d'assurance maladies au Burundi que vous connaissez?

EXPLORE POUR:
- LES FORMES D'ASSURANCE OFFICIELLE ET OFFICIEUSE QUI EXISTENT 'QU'EST CE QU'ILS SAVENT DE LA SIGNIFICATION DE CES FORMES D'ASSURANCE?
- QUELS SONT LES AVANTAGES QU'ON TIRE DU FAIT D'ETRE MEMBRE D'UN SYSTEME D'ASSURANCE MALADIE ?

2. Est-ce que votre carte d'assurance vous avantage t-elle dans la réduction des frais médicaux ?

EXPLORE POUR :
- LA CARTE D'ASSURANCE LA PLUS UTILISEE PAR LES GENS QUELLES SONT LES RAISONS QUI LES ONT POUSSE A ACHETER UNE CARTE D'ASSURANCE?
- POURQUOI CERTAINES PERSONNES N'ONT PAS DE CARTE D'ASSURANCE ?

3. Pouvez vous utiliser votre carte d'assurance dans n'importe quel établissement médical?

EXPLORE POUR:
- LA OU CE N'EST PAS POSSIBLE ET POURQUOI

4. En ce qui concerne les soins de santé, penses-vous qu'une carte d'assurance maladie vous avantage-t-elle plus par rapport à celui qui n'en aurait pas?

5. Le fait d'avoir une carte d'assurance a-t-il facilité à vous et à votre famille de bénéficier des soins de santé ?

EXPLORE POUR:
- DIFFICULTES QUE CERTAINES PRSONNES RENCONTRENT

6. Est-il possible pour les gens puissent obtenir un statut d'exemption dans la communauté?

7. Qu'est ce qu'ils doivent faire pour cela?

8. Est-ce que les enfants dans certains ménages ont-ils des attestations d'exemption? Pourquoi cela?

9. Est-ce que les enfants pensent avoir droit aux exemptions ?

EXPLORE POUR:
- L'EXISTENCE DES PROCEDURES OFFICIELLE ET OFFICEUSE D'ACQUISITION
- LES PROBLEMES DANS L'OBTENTION DU STATUT DES EXEMPTIONS
- COMMENT ILS PENSENT QUE CES PROBLEMES PEUVENT ETRE RESOLUS?
- QUELS SONT LES ABUS DANS LE SYSTEME D'EXEMPTION ?

10. Ont-ils déjà entendu parler de certaines gens qui font des payements (en dehors des procédures connues par les services de santé) ou en donnant des pourboires au personnel de santé?

EXPLORE POUR:
- VERIFIER QUE C'EST UNE PRATIQUE CONNUE
- A QUOI SERT CE PAYEMENT
- QUI EMPOCHE CET ARGENT ET CE QU'ON EN FAIT ? VERIFIER QUE CELA EST DONNE MEME S'ILS SONT EXEMPTES OU ONT UNE CARTE D'ASSURANCE
- S'ILS PENSENT QUE L'ASSURANCE QU'ILS ONT RECUE LEUR DONNENT DROIT A UN TRAITEMENT MEILLEUR OU QU'ILS APPRECIENT LE PERSONNEL DE SANTE

SUJET 5. L'approvisionnement des services de santé

1. Que pensez-vous des services sanitaires dans votre zone comparés au reste du pays?

2. Que pensez être les grands problèmes dans les services de santé dans votre zone? (mentionner 3 problèmes pour chaque type d'établissement sanitaire)

EXPLORE POUR:
- PROBLEMES DANS LES OFFICINES, LES CENTRES DE SANTE ET LES HOPITAUX PUBLICS

3. Que pensez-vous au sujet de la résolution de ces problèmes?

EXPLORE POUR:
- SOLUTIONS POUR LES 3 PROBLEMES POUR CHAQUE TYPE D'ETABLISSEMENT DE SANTE

4. Qu'est ce devrait être fait pour améliorer chaque type d'établissement sanitaire dans votre zone?

LE GUIDE DU QUESTIONNAIRE POUR LES FOCUS GROUPE DES ENFANTS (7 – 18) (GROUPE DES HOMMES, GROUPE DES FEMMES) GITEGA, MWARO, MURAMVYA

SUJET 1. La maladie et le traitement

1. Quelles sont les principales maladies qui affectent le plus les enfants? (Différencier les maladies bénignes et graves).

SUJET 2. Le comportement dans la recherche des soins de santé et la Prise de décision sur la santé.

2. Qu'est ce qui arriverait si un enfant dans ta famille était atteint d'une maladie bénigne (par exemple: tu peux prendre une maladie parmi la liste des maladies évoquées précédemment) .

EXPLORE POUR:
- QUI EST CE QU'ILS CONSULTERONT EN PREMIER LIEU ?
- LES DIFFERENCES QUI POURRAIENT EXISTER AU SEIN DES FAMILLES ENTRE HOMMES ET FEMMES .
- QUELLES SONT LES RAISONS AVANCEES POUR MOTIVER LES INITIATIVES PRISES.
- ESSAYER DE DONNER DES EXEMPLES AUTHENTIQUES .

3. Qu'est ce qui arriverait Si l'état de cet enfant s'empirait?

EXPLORE POUR:
- QUI EST CE QU'ILS CONSULTERONT EN PREMIER LIEU ?
- LES DIFFERENCES QUI POURRAIENT EXISTER AU SEIN DES FAMILLES ENTRE HOMMES ET FEMMES .
- QUELLES SONT LES RAISONS AVANCEES POUR MOTIVER LES INITIATIVES PRISES.
- ESSAYER DE DONNER DES EXEMPLES AUTHENTIQUES .

4. Qu'est ce que tu ferais si un enfant dans ta famille était atteint d'une maladie grave aigue ou blessure (par exemple: tu peux prendre une maladie parmi la liste des maladies évoquées précédemment) .

EXPLORE POUR:

- QUI EST CE QU' ILS CONSULTERONT ?
- LES DIFFERENCES QUI POURRAIENT EXISTER AU SEIN DES FAMILLE ENTRE LES HOMMES ET LES FEMMES.
- QUELLES SONT LES RAISONS AVANCEES POUR MOTIVER INITIATIVES PRISES .
- ESSAYER DE DONNER DES EXEMPLES AUTHENTIQUES

5. N'avez vous jamais eu à retarder le moment de te faire soigner (c à d une attente prolongée entre le temps de la prise de décision et le moment de te faire soigner)?

EXPLORE POUR :
- POURQUOI IL PEUT Y AVOIR UN CERTAIN RETARD DANS LA RECHERCHE DU TRAITEMENT ?

6. Quand un enfant tombe malade qui est ce qui prend la décision sur ce que l'on doit faire et où il faut s'adresser?

EXPLORE POUR:
- QUI PREND LA DECISION SELON DIFFERENTS TYPES DE MALADIES
- SELON QU'IL Y A DES DISCUSSIONS PARMI LES MEMBRES DE LA FAMILLE
- SELON QUE LE CONSEIL A ETE CHERCHE EN DEHORS DE LA CELLULE FAMILIALE (QUI SONT CES GENS)

7. As tu besoin de demander une permission pour aller chercher un traitement?

SUJET 3. Les contraintes d'accès aux soins de santé

Dans la présentation précédente , nous avons parle des sujets où certaines personnes doivent différer la date de leur traitement médical . Maintenant nous voulons connaître un peu pourquoi on peut ne pas être en mesure d'avoir accès aux soins de santé ou d' utiliser les services de santé.

6. Pour accéder aux services des santé (Cad l'officine , centre de santé public, hôpital public), que penses-tu être le plus grand problème pour les enfants?

EXPLORE POUR:
- LES COUTS DU TRAITEMENT
- LA QUALITE DES SERVICES
- LA DISTANCE
- L' EXPERIENCE ANTERIEURE

7. A quelle période de l'année , est - il difficile de payer les frais médicaux / le traitement pour les membres de la famille?

EXPLORE POUR:
- QUAND ET POURQUOI

8. Quelle est la plus grande difficulté à laquelle les differents types de ménages font face dans le payement des soins de sante ? Quels sont les ménages qui ne connaissent pas ces problèmes?

9. Y a t il des périodes où vos parents / gardiens, ont souhaité vous faire soigner , mais ne l'ont pas pu ?

10. Lorsqu' un enfant tombe malade et que la famille n'a pas d'argent pour le faire soigner, alors qu'est ce qui se passe ?

EXPLORE POUR:
- TOUTES LES STRATEGIES ENVISAGEES (Ne pas chercher de traitement, Emprunter, Recevoir de cadeaux, Vendre des récoltes / ou des biens pour collecter de l'argent).

- LES RESEAUX DE SOLIDALITES SOCIALES ET L'ECHANGE ENTRE LES MENAGES
- L'ORDRE DANS LEQUEL CES ACTIONS DEVRAIENT SE SUIVRE (par exemple vendriez – vous vos biens en premier lieu ou bien faudrait – il emprunter d'abord)
- LES DIFFERENCES SELON QU,IL S'AGIT DES MALADIES BENIGNES OU GRAVES
- L' IMPLICATION DE CES STRATEGIES (par exemple : Quelles sont les implications de la vente des biens sur les ménages ; et en particulier les implications de la dette et de l'emprunt par des moyens formels et informels sur les ménages)

SUJET 4. L'assurance et le système d'exemption

1. Combien y a t- il de types d'assurance maladie au Burundi que vous connaissez?

EXPLORE POUR:
- LES FORMES D'ASSURANCE OFFICIELLE OU OFFICIEUSE QUI EXISTENT 'QU'EST CE QU'ILS SAVENT DE LA SIGNIFICATION DES DE CES FORMES D'ASSURANCE.
- QUELS SONT LES AVANTAGES QU'ON TIRE DU FAIT D'ETRE MEMBRE D'UN SYSTEME D'ASSURANCE MALADIE.

2. Est ce que votre carte d'assurance vous avantage- t-elle dans la réduction des frais médicaux?.

EXPLORE POUR :
- LA CARTE D'ASSURANCE LA PLUS UTILISEE PAR LES GENS
- QUELLES SONT LES RAISONS QUI LES ONT POUSSEES A ACHETER UNE CARTE D'ASSURANCE
- POURQOUI CERTAINES PERSONNES N'ONT PAS DE CARTE D'ASSURANCE

3. Pouvez vous utiliser votre carte d'assurance dans n'importe quel établissement médical?

EXPLORE POUR:
- LA OU CE N'EST PAS POSSIBLE ET POURQOUI

4. En ce qui concerne les soins de santé , penses-vous qu' une carte d'assurance maladie vous avantage plus par rapport à celui qui n'en aurait pas ?

5. Le fait d'avoir une carte d'assurance a-t-il facilité à vous et votre famille de bénéficier des soins de santé?

EXPLORE POUR:
- LES DIFFICULTES QUE CERTAINES PERSONNES RENCONTRENT

6. Est il possible que les gens puissent obtenir un statut d' exemption dans la communauté?

7. Qu'est ce qu'ils doivent faire pour cela?

8. Est-ce que les enfants dans certains ménages ont – ils des attestations d'exemption? Pourquoi cela ?

9. Est ce que les enfant pensent avoir droit aux exemptions?

EXPLORE POUR:
- L'EXISTENCE DES PROCEDURES OFFICIELLES ET OFFICIEUSES D' ACQUISITION.
- LES PROBLEMES DANS L'OBTENTION DU STATUT DES EXEMPTIONS
- COMMENT ILS PENSENT QUE CES PROBLEMES PEUVENT ETRE RESOLUS
- QUELS SONT LES ABUS DANS LE SYSTEME D'EXEMPTION.

10. Ont ils déjà entendu parlé de certaines gens qui font des payements (en dehors des procédures connues par les services de santé) ou en donnant des pourboires au personnel de santé ?

EXPLORE POUR:
- VERIFIER QUE C'EST UNE PRATIQUE CONNUE
- A QUOI SERT CE PAYEMENT ?
- QUI EMPOCHE CET ARGENT ET CE QU'ON EN FAIT
- VERIFIER QUE CELA EST DONNE MEME S'ILS SONT EXEMPTES OU ONT UNE CARTE D'ASSURANCE.
- S'ILS PENSENT QUE L'ASSURANCE QU'ILS ONT RECUE LEUR DONNE DROIT A UN TRAITEMENT MEILLEUR OU QU'ILS APPRECIENT LE PERSONNEL DE SANTE.

SUJET 5. L'approvisionnement des services de santé

1. Que pensez – vous des services sanitaires dans votre zone comparée au reste du pays?

2. Que pensez – vous être les grands problèmes des services de santé dans votre zone? (mentionner 3 problèmes pour chaque type d'établissement sanitaire).

EXPLORE POUR :
- PROBLEMES DANS LES OFFICINES, LES CENTRES DE SANTE ET LES HOPITAUX PUBLICS

3. Que pensez- vous au sujet de la résolution de ces problèmes?

EXPLORE POUR:
- SOLUTIONS POUR LES 3 PROBLEMES POUR CHAQUE TYPE D'ETABLISSEMENT DE SANTE .

4. Qu'est-ce qui devrait être fait pour améliorer les soins de santé offerts aux enfants de votre zone?

XIII. ANNEX 9: A list of health facilities in the provinces of Gitega, Mwaro and Muramvya

CENTRES PUBLIC, AGREES ET PRIVES DANS LES PROVINCES DE GITEGA, MWARO ET MURAMVYA

PROVINCES	CdS PUBLICS	CdS RELIGIEUX	CdS PRIVES	HOPITAUX
Mwaro	Kanka	Mbogora	Mwaro	Kimbumbu public
	Bisoro	Muyebe		Sanatorium public
	Rorero	Rusaka		
	Gisozi			
	Kibumbu			
	Kibimba			
	Nyakararo			
	Mutumba			
	Rwintare			
	Yanza			
	Fota			
	Ndava			
	Nyabihanga			
	Kibungere			
Gitega	Gitega	Mushasha	Gahore	Gitega public
	Mubuga	Songa	Musinzira	Kibuye protestant
	Rutoke	Murayi	Nduwumwami	Mutaho public
	Giheta	Kibimba	Rema-clinique	
	Bukinga	Kibuye	Yoba	
	Makebuko	Nyangwa	Espoir	
	Muramvya	Ntita	Gitongo	
	Buhinda	Nyabiraba		
	Gisikara	Mutoyi		
	Prison de Gitega	Mugera		
	Bukirasazi	Rwisabi		
	Buraza			
	Gishubi			
	Nyarusange			
	Mutaho			
	Bugendana			
Muramvya	Kaniga	Munanira		Kiganda public
	Kiganda	Bukeye		Muramvya public
	Kivoga	Gatabo		
	Gasura	Ryarusera		
	Muramvya	Shombo		
	Bugarama			
	Busangana			
	Teza			
	Shumba			
	Nyarucamo			